Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 4:25 AM 001 Novembe Jaron DIO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner NorThwest andalktown Hospita Jeriter BAltiMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth (Month, Day, Mar 28, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours 578-50-9881 71 1938 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinist must be notified at 1 ☐ Yes 2X No Director COLUMBIA MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 10440 Swift Stream Place #204 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No Specify: Specify: White ş 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Retail Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Auldine Meek Francis Joseph Spalding ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once. 9803 Eagle Creek Circle Commerce City, CO 80022 Cynthia A. Reynolds/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/09/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. failure Immediate Cause (Final Multiple organ system Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner inflammator response Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Herine cordin ornas been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform ormed**7** 2 **W**No this certificate 20 2 No OTIP malnuti 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

P.O. Box 68760, Division of Vital Records, To the Hospital o within 24 hours af To the Funeral Di

> State Registrar

completely

29b. Signature and title of certifie

31. Date filed (Month

Boston

20101Ta

29c. License number

D28462

Center Pandallstown

29d. Date signed (Month, Day, Year)

and manner stated

Northwest

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 28, 2009 October 3:40 JERRY WELDON STUDY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Braddock Heights Vindobona Nursing Home 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, July 1, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral №** M 2□ F Months Days Hours 213-12-7486 86 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location 10a. State 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Ever, iner must be exhibited at 1 □ Yes 2 No Frederick Director Maryland Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12506 Sandra Lee Court 21770 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tool Maker U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Scott Luther Study Roma Arlene Markoe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau once. Louise E. Study / Wife 12506 Sandra Lee Court, Monrovia, MD 21770 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 11/3/09 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundiral Service I ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or conshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, cruse on each Immediate Cause (Final disease or condition resulting in death) Physician カカイら /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. چ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si al director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 PNo 1 ☐Yes 2 ☐No 1 □Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies OCT, 28, 2009 20061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gaffer Syed, MD 801 Toll House Avenue H4, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 8, 2009 9:41 A M Daniel Martin Scholl Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 213 Holland Ave. Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ste Country) April 22,1947 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Sex Days 1XM 2□ F Months Hours 62 216-44-8038 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Ty Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 213 Holland Avenue 21804 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Code Inspector Town Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mozell Lori Childress Daniel Martin Scholl, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori K. Scholl/Daughter 120 Cherry Court, Clayton, North Carolina 27520 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 11/9/2009 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign viure Funeral Service Lie 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salibsury, MD 21802 Approximate Interval Between Onset and Death Part L Enter the disease, or complications that caused the death shock, or heart failure. List only one cause of ach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

and

certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Director

Funeral

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Completed

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10a. State

**Examiner** 

**Funeral** 

Director

'natural', or items 23a or 28a-f show Examiner must be notifled at

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Men

Baltimore, Maryland 21215-0036

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Examiner Physician/Medical \$ Completed Be 2

Certification:

attending physician detached the ģ The law requires that signed s been signer has certificate Attending Physician; To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di this

State Registrar

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 1 ☐ Yes 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) H57291

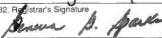
2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lysican

Suite 101, Solishun, mD 21804 J.C. Patrowicz, D.O. 1820 Sweet Bay Drive,

31. Date filed (Month, Day, Year) NOV 10



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November WILLARD J. STANLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours 2/25/1923 1 □XM 2 □ F 233-30-8925 86 WEST VIRGINIA Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director HAGERSTOWN 1 Yes 2 □ No MD WASHINGTON 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral items 23a USA 333 MILL STREET 21740 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married "natural", or 2 Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
CARPENTER event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry HEAVY CONSTRUCTION and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked one any injury or other traumatic eve once. ഉ MYRTLE LAFFON JESSE E. STANLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 188 RELIANCE ROAD, MARTINSBURG, WV 25403 FRANKLIN P. STANLEY/BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOVEMBER 1 Burial 2 X Cremation 3 Removal from State SMITHSBURG CREMATORY SMITHSBURG, MD 4 Donation 5 Other (Specify) 18.2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 327 W. KING ST., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEUMONI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): nding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes 4 ☐ Preynant. 9 ☐ Unknown been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy certificate has 2 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural Accident iniury 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the

State Registrar

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29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOV 2

30. Name and address of person who completed

mm

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cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Dav. Year)

11/15/2000

**Physician** /Medical Examiner Examine

burial-tran and

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signed by the a

nis certificate has been si director, page 2 should

funeral

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completely

Physician/Medical

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Completed

Be

Certification: To

Medical

attending physician

law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

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Completed

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MD

**Funeral** 

Director

ed other than "natural", or Items 23a or 28a-f shov event, the Wedical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important; if item 27 is marked other than any injury or other transmeth.

Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 ☐ Unknow

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

newo 25. Was case referred to media examiner?

1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 **X** No 1 ☐ Yes

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 ☐ Could not be

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

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Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

within 24 hours a

State Registrar

ause of death (Item 23a) (Type, Print) 30. Name and address of person w

Michael Epstein

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physic	ian	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	23-20	Year	3. Time of Death
/Medi-		4a. Facility Name (If not institution, gi		493	4b. City, Town, o	r Location of Death			nty of Death	, , –
Funeral	۳	5. Social Security Number 6.		(In yrs. last birt	Hoday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 3/12/1	v. Year)	9. Birth	place (State or Foreig intry) MD
D		Usual Residence of Decedent					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			10d. Inside City Limits
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the M 28a-f	recto	MD Kent  10e. Street and Number		Worte	10f. Zip Code			10g. Citizen o	of What Cou	intry?
3a or	i Di	11177 Potts Road			21678	3		USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in Modeal Everning must be notified at appear.	by Funeral Director	11. Marital Status  1 ♣Never Married 2 Married 3 ₩Idowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □Yes 2 2 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 □Yes 2 ☒No		pecify Yes or No Rican, etc.)		ace - Amer lack, White cify: Bla	
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Hygie Hygie ther ti nt, th	ပို	12 17. Father's Name (First, Middle, Las	<u>1</u>	N	lurse	18. Mother's Nam	ne (First, Middle,		.th Ca ame)	re
d be f ental ked of	To Be	Isaac Thomas	,			Mary E.	,			
shoul and Mi marl	=	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numb	er, City or Tow	vn, State, Z	ip Code)
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permit Depart Import any In		21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or conshock, or heart failure. List only	Skelful	Pain	Fellows, F 130 Speer	Rd. Chest	tertown,	MD 21	eral 620	Home
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as a	re si	ubdural V	Venuton Nomet	nu -			Onset and Death
ate be executed hysician and the burial-transit	fical Examiner	ir any, leauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of	ul).	CERTIFICATION APP	ROVED MEDIC	CAL EXAMINER		
death certif e attending d for use as	edical	Cause (Disease or injury that initiated events	c	consequence of pregnancy	of):		ROVED MEDIN		Date of del	ivery Day Year
death certiff e attending d for use as	by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c.  Due to (or as a  d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	f pregnancy Fetal death ime of death	of):  3	су	23e. Did t		Month ontribute to	Day Year the cause of death?
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# 23 An B

		1 - For State Registrar	State of	Maryland / I		artment of H		and Me		giene Reg. No. 2 ()	109	37	507
Physic /Med	ical	1. Decedent's Name (First, Middle Esther Tange					(		2. Date of Dea Month 11/0	2/2009	Year	3. Time of 4:04	
Exami	iner	4a. Facility Name (If not institution  39 Aventura Co	ourt	<i>'</i>		4b. City, Town, or Randals  If Under 1 Year	stown				timor	e City	•
Funera Director		5. Social Security Number N/A Usual Residence of Decedent	6. Sex 7	. Age (In yrs. last bii	Yrs.	Months Days	Hours	Min.	8. Date of Birti (Month, Day Sept 1	n , <i>Year)</i> . <b>7,</b> 1949		lace (State of try) eroon	
e Maryland 3a-f show Ilfied at	ctor	10a. State 10b. County  MD Balti	more	10c. City, Tow							1	0d. Inside C	ity Limits 2 □ No
th with th	Funeral Director	10e. Street and Number 39 Aventura Cou	ırt			10f. Zip Code 21133				10g. Citizen of \ Came	What Coun rooni		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mant to notified at angles.	þ	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, Give Year or Dat	es? MNo es:		Was Decedent of Hi fYes, specify Cuba 1 □ Yes 2 No	Specify:	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)		ce - Americ ck, White, e	k	
within 72 jiene. r than "nat	Completed	15. Deceden (Specify only highe) Elementary/Secondary (0-12) 12th	st grade completed)  College (1-4		(Give	dent's Usual Occupa kind of work done o DO NOT use retired Housew	turing most )	t of working	g		vate	usuy	
uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, James Tamun	*		_			r's Name		Maiden Surnan Known	ne)		
and 2 sho ealth and I m 27 is ma		19a. Informant's Name/Relations Olivia Tange /		- 1		ng Address <i>(Street a</i> Ventura Co						-	
Pages 1 and of the out; If item		20a. Method of Disposition  1 X Buria! 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		ate 20b. Place o	f Dispo	sition (Name of natory or other place	e)	Da	ite	20c. Location -	- City or To	wn, State	
permit. Departm Importa any inju		21. So nture of Fundament Service		·	22	Name and Address	s of Facility	y J.	B. Jenl	kins Fu	neral	Home	
Physician /Medical bubblistician and the burial-transit		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	th line.  Liver Fai  as a consequence  Hepatits  as a consequence  Hypertens  as a consequence	of): C of):	е	g, Sucri as	cardiac of	respiratory an	rest,		Approximation	tween
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as la	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2 □ Fetal death nt at time of death vn		Ectopic pregnancy Other (specify)	/				ite of deliver		Year
quires that in signed build be deta	þ	Part II. Other significant condition	ons contributing to dea	th but not resulting i	n the ui	nderlying cause give	en in Part I.		23e. Did to	obacco use conf ′es 2 ဩ No			death? Unknown
ician: The law requir certificate has been si ector, page 2 should I	Completed								24a. Was a autop perfor 1 🗆 Yes	med?	Were auto prior to co death? 1 ☐ Yes	psy findings mpletion of c	available cause of
tending Physical Seath.  tor: After this the funeral dir	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2XXNo  27. Manner of Death  1XXNatural 5 Pendin 2 Accident investig 3 Suicide 6 Could	g 28a. Date of (Month, gation not be 28a. Place of		Time of Injury	28c. Injury Work M 1 🗀	er: 4 🗆 Nu	rsing Hom 28	8d. Describe h	ne)  dence 6 ☐ Oth  now injury occur  Street and Numb	red		mhor
spital or At hours after of neral Direct y filled in by		4 ☐ Homicide determ  29a. Certifier	building ng Physician: To the b	i, etc. <i>(Specify)</i> est of my knowledgi	e, deatl	n occurred at the tin	ne, date an	nd place, a	City or Tow	m, State) cause(s) and m	anner as s	tated.	
To the Hosp within 24 ho To the Fune completely f	Medical	(Check only one)  2 Medical  29b. Signature and title of certifie	Examiner: On the bas and manne		nd/or in	vestigation, in my o		th occurre		date and place, 29d. Date signe			s)
		30. Name and address of person	e Mure	1 Tho	/T	D 353	30			Novemb	oer 3	, 2009	)
23		Dr. Charles Mo	ore, 4 East	t Rollin	Cros	ss Road,	#102,	Cant	onsvil	le 2122	.8		
St Regist	tate trar	NOV 1 0 2009	Berena	jistrar's Signatur	Re	•							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician William Chesley Tuck 2009 5:15 A M November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Renaissance Gardens Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 15, 9. Birthplace (State or Foreign Social Security Number Sex 1X M 2□ F 7. Age (In yrs. last birthday, **Funeral** Days Colorado 85 Director 347-18-3979 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wedical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Prince George's Silver Spring 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number USA 3160 Gracefield Road RC1519 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 A∑lYes 2 □ No If Yes, Give Year or Dates: 1943–45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. nours after 1 Never Married 2 Married 0. Maryland 21215-0036 1∐Yes 2XX No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 1 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Minister Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be file I Health and Mental H tem 27 is marked oth Be Helen Marr Leslie James Tuck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary T. Staley/daughter 5805 Ogden Road Bethesda, MD 20816 permit. Pages 1 and Department of Health Important: If item 27 any injury or other toonce. altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 11/06/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie Ging Home Cremation Service P.O. Box 784 Telegraphy Mol 251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nysician Parkinson's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) requires that the death certificate be executed Exami burial-tra Due to (or as a consequence of) Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s page certificate 1 □Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) assisted Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{MOther (Specify)} \) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To <del>livina</del> After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🛮 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A propletely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P within 24 To the F complet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 5, 2009 D36716

12+1

State Registrar 3110 Gracefield Road Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Registrar's Signature

M.D.

Andrew Kundrat,

31. Date filed (Month, Day

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	-	epartment of Certificate o	Health and M		0000	07500
			Registrar  1. Decedent's Name (First, Middle, Last)		Jer lineale of	Dealli	Reg. N	2005	3. Time of Death
	Physici	an	Donna C. Tannir					6, 2009	8:50 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number	.)	4b. City, Town	, or Location of Death	4	4c. County of Deat	h
			3713 Dorsey Search Circle			cott City		Howard	
	Funeral Director		5. Social Security Number 6. Sex 1	ige (In yrs. last birth 63	Months Day		8. Date of Birth (Month, Day, Yea 9/19/194	9. Birtl Co Net	hplace (State or Foreign untry) VYork
	7		Usual Residence of Decedent	10c. City, Town	or Location				10d. Inside City Limits
	arylar show ed at	_	10a. State 10b. County	,,					1 Tyes 2 No
	the M 28a-f lotifle	ecto	Md. Howard  10e. Street and Number	ETTIC	ott City  10f. Zip Code	3	10g.	Citizen of What Co	ountry?
	with 3a or 1 be r	Ω	3713 Dorsey Search Circle	3	210			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Deceden Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	it Ever in U.S. ? ••••••••••••••••••••••••••••••••••	13. Was Decedent of If Yes, specify C	f Hispanic Origin? (Sp uban, Mexican, Puerto lo <i>Sp</i> ec <i>ify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	2 hou latura ical E	ted	15. Decedent's Education	16a. [	Decedent's Usual Oct (Give kind of work de	cupation	ing 16b	. Kind of Business/	Industry
215	thin 7; e. an "n Medi	aldu	(Specify only highest grade completed)  Elementary/Secondary (0-12)College (1-4or	r5+) l		ne during most of work ired)	ang		
7	ed wil ygien <b>ier th</b> <b>t, the</b>	Completed	5+ yrs	Sc.	hool Admir		e (First, Middle, Maid	Educat	ion
ī	be file ad oth even	Be	17. Father's Name (First, Middle, Last)				e ( <i>First, Middie, Maid</i> a Stalega	ien Surname)	
<u>Z</u>	hould d Mer marke matic	ဥ	James Vallino  19a. Informant's Name/Relationship (Type. Print)	19h	Mailing Address (Stre	eet and Number or Ru		tv or Town, State, 2	Zip Code)
Ma	nd 2 s Ith an 27 is i traui		Anis Tannir/husband		•	Search Cir			
ē,	s 1 ar f Hea ltem 2		20a. Method of Disposition	20b. Place of I	Disposition (Name of y, crematory or other p			. Location - City or	
E	Page nent of nt: If		1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e		1	/12/09 B	erwick,Pa	a.
Baltimore,	permit. Departra Importa any inju		21. Signatury of Funeral Serve Lincose e	MOO845	4112 Old	Columbia I	Pike Ellic	ke's Fami ott City	
	Physician	g q	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition a.	ed the death. Do not line.  Legislate the death of the death of the death. Do not not line.  As a consequence of	. 223	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			as a consequence of					Years
	Je II	ner	Cognoptially list conditions	s a consequence of					Years Years
	scuted nd transit	Examiner	triat iritiated events	Sipolar					Tears
30,	cate be executed physician and the burial-transit	E E	resulting in death) Last Due to (or a	as a consequence of	f):				
8760,	cate b	dical	d						
.O. Box 6	the death certificate be executed y the attending physician and Iched for use as the burial-transit	Physician/Me		2 ☐ Fetal death at time of death	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date of de Month	elivery Day Year
Δ.	ires that the de signed by the a be detached f		Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause	given in Part I.	23e. Did tobacc	co use contribute t	o the cause of death?
ds	requires that een signed b nould be deta	d by					1 ☐ Yes	2 <b>⊠</b> No 3 □ P	robably 4 □Unknown
Records,	law as b 2 sl	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
= E	(0 17	Con					performed 1 Yes 2 X	d? death? ]No 1 ☐ Yes	
Vital	siclan: certific rector,	Be	25. Was case referred to medical examiner?			26. Place of Dea	th Check onl one		
o	Phys this al di	<u>۵</u>	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inpa  27, Manner of Death 28a. Date of Ir		patient 3 DOA	4 ⊔ Nursing H	ome 5 Residence 28d. Describe how i		ecify)
on	ding I h. After funer	tion	1 Natural 5 Pending (Month, Decident Investigation		njury \	njury at Work? I □ Yes 2 □ No		.,,	
Division	al or Attending s after death. Il Director: Afte	Certification:	3 Suicide 6 Could not be 28e. Place of i	injury - At home, fan etc. <i>(Specify)</i>	rm, street, factory, offi	ce	28f. Location (Stree City or Town, S	t and Number or R state)	Bural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	ledical C	29a. Certifier (Check only one)  **Certifying Physician: To the best and manner  **Description of the description of the descri	s of examination and	, death occurred at th d/or investigation, in r	e time, date and place ny opinion, death occu	e, and due to the caus erred at the time, date	e(s) and manner a and place, and du	s stated. le to the cause(s)
	To the I within 2. To the I сопрет	Me	29b. Signature and title of certifier	No.		ense number	i	Date signed (Mon	
	1		Depotter las, M.	0	Do	0055810		Nov, 9	2009
_	Ь		7 11 11 11 11 11 11 11 11 11 11 11 11 11	4801 Do	Type, Print)	U Drive	svite 20	1 Eller	2009 off City, MO 21842
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Pigit	strar's Signature	house				

DHMH 17 Rev 1/2001

**ORIGINAL** 

				State of Marylan	66, D 088 Cer	yb4926 tificate	i dealth ai of Death			ne2009	
н	Physicia	20	Decedent's Name (First, Middle, Last)						ate of Death Ionth	30,2009 Year	3. Time of Death
	/Medic		Linda Carol Tho						tober .		
>	Examin	er	4a. Facility Name (If not institution give Frederick Heinor	<del>-</del>			wn, or Location of	Death		4c. County of Dea	
М			400 West 7th St 5. Social Security Number 6. Sec		last hirthday)	Fred	erick Year   If Under 2	4 Hrs. 8 D	ate of Birth		
	Funeral Director		10	M 25 F 60	Yrs.		Days Hours	Min. 01	715/19	49 Wes	thplace (State or Foreign ountry) t Virginia
			233-82-2732 Usual Residence of Decedent	Λ 00							
poelv	MO T		10a. State 10b. County		y, Town or Lo						10d. Inside City Limits
N C	a pa	ţ	MD. Frederick	Roc	cky Ric	lge					1 ☐ Yes 2 KNo
t at	28,	Director	10e. Street and Number			10f. Zip Co	ode			. Citizen of What C	ountry?
£	23a c		13424-A Old Freder	rick Road		2177	78		U	ISA	
9	8 5	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent f Yes, specify	nt of Hispanic Origi Cuban, Mexican,	in? (Specify ' Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Whi	
و ق	유를	F	1 Never Married 2 Married	1 ☐ Yes 2 Mo If Yes, Give		1 □ Yes 2	No Specify:			Specify: W	hite
.UU.30 hours after death with the Maryland	EX	d by	3 Widowed 4 Divorced	Year or Dates:	16a Door	dont's House C	Decumation		16	b. Kind of Business	
<b>.</b>	Tel.	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual ( kind of work of DO NOT use	done during most	of working	10	D. Kind of Dusiness	a middau y
CLZI.	then then	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemal	,			None	
מ ס	Hygin Hygin		1.2 grade  17. Father's Name (First, Middle, Last)			Пошеша		's Name (Fir	st, Middle, Ma	iden Sumame)	
	Mental arked o	To Be	Thomas Ward				Et1	hel Sm	ith		
aryia	and Mental le marked d aumatic av	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address (S	Street and Number	r or Rural Ro	ute Number, C	ity or Town, State,	Zip Code)
			Donald B. Thomps	on, Husband	13424	-A 01d	Frederi	ck Roa	d, Rocl	ky Ridge,	MD. 21778
o -	item othe		20a. Method of Disposition	1 (	Place of Dispo cemetery, crer	sition (Name matory or othe	of er place)	Date	20	c. Location - City o	r Town, State
ב ב	Department of H Important: if ite any injury or of 2002.		1 ♣ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	B1	ue Rid	ge Cem	etery No	ov.4,	2009 Tl	nurmont,	MD. 21788
	partin ports y inju		21. Signature of Funeral Service Lion	90 / De O 10						•	Son F.H.PA.
ם מ	20 = 20		Soles	Kuley							yland 21788
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the deat ne cause on each line.	Do not ent	er the mode of	of dying, such as o	cardiac or res	piratory arrest		Approximate Interval Between Onset and Death
s P	hysician		Immediate Cause (Final disease or condition	. AS	CVI	1.					Oriset and Death
	/Medical xaminer		resulting in death)	Due to (or as a consec	uence of):						
F.	xammer	_	Sequentially list conditions,	b. ————————————————————————————————————							
7	sit	line	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence on:						
of Vital Records, P.O. Box 68760,	physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
8760,	ician	aiE									
687	phys s the	edicai		o							
X	attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of de	elivery
Box	atte 1 for 1	ciai	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		⊒Ectopic preg ∃ Other (s <i>pec</i>				Month	Day Year
P.O.	ned by the a	hys	9 Unknown	9□Unknown							
	igned to	by Physician/M	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cau	ise given in Part I.		23e. Did toba	cco use contribute	to the cause of death?
Ď.	been sig should b		- po	VAMI	)			_	1 Yes	2 □ No 3 □ F	Probably 4 Unknown
S S	as bee 2 sho	Completed	Celus	1 ceman					24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
ř	ite has	E	/						performe	d?   death?	es 2 No
<u>g</u>	r this certificate has	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Ch	eck only one)		
>	direce	P.	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3E DOA	Other: 4 Nur	rsing Home	5 Residen	ce 6 Other (Sp	pecify)
0 2	fter th	ü	27. Mann of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		c. Injury at Work?	1	Describe how	injury occurred	
Sio	death.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 Yes 2 N		1 (04		Over Bouto Mumbos
Division of Vital Records,	after death Diractor:	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, st fy)	reet, factory,	office	281.	City or Town,	State)	Rural Route Number,
	urs a arai C		Continue Physics	raining To the best of multip		h	the time data and	d place and	due to the gove	co(s) and manner	as stated
	ine frospical of Acceptance and 24 hours after death.  the Funeral Diractor: After a polestely filled in by the fune	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kni iner: On the basis of examination and manner stated.	ation and/or in	vestigation, in	n my opinion, deat	th occurred a	t the time, date	e and place, and d	ue to the cause(s)
	within 24 hours after death.  To the Funeral Diractor: After completely filled in by the funer	Med	29b. Signature and title of certifier			29c.	License number		290	. Date signed (Mo	nth, Day, Year)
) '	- s ⊢ ō						01754	9		11/4/0	9
r	n		30. Name and address of primon who d	ompleted cause of death (Ite	m 23a) (Type.		toctin M	/	Group		•
	1		William F. Harpe								land 21788
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Spar	Kal				
	Regist		NOV O	5 2009 Lever	-62	LA CIN	Red				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland	-	artmen tificate			and M	ental Hyg	iene <sub>eg. N</sub> 200	9	37511
	Dhusisi		1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	Dav	Year	3. Time of Death
	Physicia /Medic		Robert Vernor	<u> </u>		<del></del>					Novembe	r 13,20		1:40 A M
4	Examin	er	4a. Facility Name (If not institution, give		er)		4b. City, Hanc	_	Location o	of Death		4c. County	or Death lingt	on
			14663 High German  5. Social Security Number 6. Se		Age (In yrs. la	st hirthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth			place (State or Foreign
	Funeral Director		218-24-9707	M 2□F		80 Yrs.	Months	Days	Hours	Min.	(Month, Day Sept. 25	, Year)	MI	
	ט		Usual Residence of Decedent		40. 03	<del>-</del> .								10d. Inside City Limits
	show	_	10a. State 10b. County  MD Washingt	on		, Town or Lo 1cock	cation							1 ☐ Yes 2X☐ No
	8a-1	Director			IIai	ICOCK	404 7im	Codo				10g. Citizen of V	What Cour	
	within 72 hours after death with the Maryland ane. than 'natural', or Itams 23a or 28a-f show ta Madical Examiner must be notified at	Dir	10e. Street and Number 14663 High German	ıv Road			10f. Zip	1750				USA		,
	hs 23	Funeral	11. Marital Status	12. Was Decede		S. 13. V	Nas Dece	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Rac		can Indian,
ဖ	or itar		1 ☐ Never Married 2 X Married	Armed Force 1 ☐ Yes 2 If Yes, Give			t Yes, spec 1 ☐ Yes		n, Mexican Specity:	i, Puerto i	Rican, etc.)	Specify	ck, White,	
93	iral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	9S:								MIIT	
21215-0036	"natu	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced	dent's Usua kind of wo DO NOT us	rk done d	uring most	t of workin	ng	16b. Kind of B	usiness/In	dustry
12	withir ene. than	ф	Elementary/Secondary (0-12)	College (1-4	or 5+)		hiner			or	-	Truck Ma	anufa	acture
d 2	Hygie other ant, II	Be C	17. Father's Name (First, Middle, Last)		- 1	<del></del>					(First, Middle,	Maiden Suman	10)	
an	ould be Mental Marked o	To B	Emory Thompson						Pear	l Mit	chell			
Maryland	2 should and Men is marke sumatic	ý 1	19a. Informant's Name/Relationship (7									r, City or Town,		
	and and m 27		Ora M. Thompson/W	ife	20h 21	7.00	_				lancock ate	Marylar 20c. Location		21750
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, Ita Madical Examinar must be notified at anone.	1	20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐		ale	ace of Dispo emetery, cren								
tim	E E E	1 4	<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>		Tonc	loway						eedmore Main St		
Ba	permit. Departn Importe any inju	V 1	21. Signature of Fullerar Service East	2/10	0							cock,MD		50-0368
760,62	Physician and hysician and hysician and the buriat-transit	ilcai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequer as a consequer	ence of):	C		n C	01	squ	amou	2)	Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pr						te of deliventh	rery Day Year
	w requires that been signed b should be deta	by	Part II. Other significent conditions of	ontributing to dea	th but not resu	ulting in the u	nderlying o	ause give	en in Part I			bacco use con es 2 No	tribute to	the cause of death? bably 4 Unknown
Il Records,		Completed									24a. Was autop perfor 1 🗆 Yes	sy med?	prior to co death?	opsy findings available ompletion of cause of 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	oc.		(Check only o		(0	7E.1
ō	E	To.	1 ☐ Yes 278 No 27. Manner of Death	28a, Date of	natient 2 1	28b. Time of		28c. Injury Work	4 🗆 NU	rsing Ho	, ,	lence 6 Oth		(y)
o	Attending Phy is death. ector: After thi by the funeral o	tion	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м		c? Yes 2 □	No				
Division	el or Attendi s after death. Il Director: A id in by the fu	Certification;	3 Suicide 6 Could not be determined	28A PIACE O	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factor	y, office			28f. Location (5 City or Tow		ber or Rui	ral Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Certifying Ph (Check only one)		is of examinat									
)	To the within To the comp	Ž	29b. Signature and title of certifier	10		nd	29	c. License	number	D4	6473	29d. Date signe	d (Month	, Day, Year) 6 200 9
	A		30. Name and address of person who	dan,	MD	; 113	Print)	04	PAL	. c	T. ; +	agen	ste u	on, mo 2174
	Sta Registi		31. Date filed (Month, Day, Year)	General 32. Reg	gistraris Signal	ad	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Emile Huang Wefald 2009  $P^{M}$ November 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Year Days Min 1 □ M 2 🛛 F 87 1922 China Director 578-46-1660 March Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Montgomery Montgomery Village Director Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 9833 Canal Road United States death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. à Specify. 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **Federal** Elementary/Secondary (0-12) College (1-4or 5+) Contract Translator Government 5+ Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yu Zhi Huang Jing Xi Chen ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Harold E. Wefald 9833 Canal Road, Montgomery Village, MD 20886 (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Nov. 5, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, Virginia 4 Donation 5 ☐ Other (Specify) matory 2009 Alexandria, Virg 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service M00689 Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate C use (Final disease or condition resulting in death)

Pneumonia Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🛣 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ page 2 should be Alzheimers Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1 ☐Yes 2 🛛 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitan c. within 24 hours after death.

To the Funeral Director: Aftremental Filed in by the further further filed in by the further filed in by the further filed in th 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifip 29d. Date signed (Month, Day, Year) , m.D.

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Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 06

Medical Center Drive, Rockville, ms

		1 - For State Registrar			k Indelible Ink 6/15/10 TT Department of I Certificate of		_	. No. 20	~ ~	375	
hysic	ian	1. Decedent's Name (First, Middle, L	,				2. Date of Death Month	Day	Year	3. Time of De	eath
/Medi	ical		OHN DAVID W	ILSON			NOV 8	2009		2:59 E	) 
Exami	ner	4a. Facility Name (If not institution, ga	,	CMED		or Location of Death		4c. County		22.5	
uneral			Sex 7. Age	LNILK (In yrs. last bir	thday) If Under 1 Year		8. Date of Birth		GOME 9. Birthp	lace (State or F	ore
rector		288-74-5065 Usual Residence of Decedent	1∏ M 2□ F	39	Yrs. Months Days	Hours Min.	SEPT. 27,		Coun O	HIO	
Wor		10a. State 10b. County		10c. City, Towr	n or Location				10	0d. Inside City I	Limi
lifed	ctor	MD. MONTGO	MERY		CLARKSBU	RG				ty∑Yes 2	
or 26	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of V	hat Coun	try?	
s 23a	eral	12952 CLARKSI				20871			S.A.		
r item iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 √2 Yes 2 □ No		13. Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)		e - Americ k, White, e		
ral", o	ģ	3 ☐ Widowed 4 ☐ Divorced	1√Yes 2 No liYes, Give Year or Dates:1 9	990-200	9 1 □ Yes 2√ No	Specify:		Specify	· WHI	TE	
natri Nest	etec	15. Decedent's E (Specify only highest gi	Education rade completed)	16a.	Decedent's Usual Occup (Give kind of work done		ina 1	b. Kind of Bu	siness/Ind	lustry	
than,	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	)	U.S. NAV	d)		т	ATO TO TO A	CIE	
marked other than "natural", or items 23a or 28a-f show .matic event, It e Madical Examinar must be notified at	Be Co	17. Father's Name (First, Middle, Las	it)		U.5. NAV	I	e (First, Middle, Ma		EFEN:	O.E.	
rked tíc ev	To B	JIMMY I	DALE WILSO	ON			LPHIA	KENNE	,		
If item 27 is marke or other traumatic		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street					Code)	
m 27 ner tr		_ ANGELA RENEE WI	LLSON/WIFE		2952 CLARKS		RE RD., C	LARKSE	URG,	MD.208	71
r ite orotl		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	☐ Removal from State	20b. Place of cemeter	Disposition (Name of ry, crematory or other place	ce)	Date 20	c. Location -	City or To	wn, State	
Important: I any Injury o once.		4 ☐ Donation 5 ☐ Other (Special	ify)	ARLIN	GTON NAT'L.					N, VA.	
any l		21. Signature of Funeral Service Lice	ensee	2	CHAMBERS	ss of Facility FUNERAL H	OME & CRE	MATORI	UM,P	.A.	
		W-W. Gu			1 5001 07 777	TT A ATTS	T) T T T T T T T Y Y	AT 77 34	0.4	0707	
sician edical miner		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	implications that caused the vone cause on each line  a.  Due to (or as a	ne death. Doir <del>NG</del> Ae:	$1 \mid 5801$ CLEVI not enter the mode of dyin ${ t rosol}$ Inhala	ELAND AVE	., RIVERD or respiratory arrest	ALE, M	D. 20	0737 Approximate Interval Betwee Onset and Dea	en ath
edical niner	xaminer	Immediate Cause (Final disease or condition	y one cause on each line PENDT	NG Ae:	1 5801 CLEVI not enter the mode of dying rosol Inhala	ELAND AVE	., RIVERD or respiratory arrest	ALE, M	D. 20	0737 Approximate Interval Between	en ath
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 338 M 30 2009 10 Abraham 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Hospital Anne Arundel Annapolis Date of Birth (Month, Day, Year) 12-27-1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 517-74-7163 10 M 20 F Months Days Hours Min. Washington, DC 53 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 TYes 2 □ No Upper Marlboro MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 U.S.A. 17024 Fairway View Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIII o If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X**No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Real Estate Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Lee Williams Sr. Florene Stokes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela D. Williams - Wife 17024 Fairway View Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 11-07-2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign sure of Fun All Service 22. Name and Address of Facility J.B. Jenkins Funeral Home 7.5 7474 Landover Road, Landover Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final olon cancer YEAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an

Physician /Medical Examiner

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lijury or other traumatic evone.

**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modified at

2 should be filed within 72 hours after death with In and Mental Hygiene.

is marked other than "natural", or items 23a or:

Baltimore, Maryland 21215-0036

the Maryland

rial-tran

The law requires that the death certificate be executed

Box 68760,

P.O.

25. Was case referred to medical

examiner's

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only onel

29b. Signature and title of certifier

1 Yes 2 No

attending physician this

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n: To Be Completed by Physician/Medical
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27. Manper of Death Certificatio

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Medical State Registrar

Division of Vital Records, lospital or Attending P thours after death.
'uneral Director: After tely filled in by the funera To the Hospital within 24 hours a To the Funeral L Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wal 31. Date filed (Month, NOV 1 0 2009

5 Pending investigation

6 Could not be determined

Inpatient

28a. Date of Injury (Month, Day, Year)

29c. License number D0057984

1 ☐ Yes 2 ☐ No

Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

November 2, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Luis Alberto Diaz

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2069 David L. Watson, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Regional 11 LISBULL MICANICO PENINSUM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 **X**M 2 □ F Months Days Hours Min 199-18-4369 85 May 20, 1924 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 Chippewa Blvd. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Army If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: African-3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Educator Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Watson Annie West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Watson/wife 1007 Chippewa Blvd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/07/2009 Hebron, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CEREBROVASCULAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions II any, sacing to in mounte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) q Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Box 68760, o σ, of Vital Records,

Physician: The law requires that the death certificate be executed physician s the burial ending puse as t or signed by the a page 2 s After this spital or Attending Pours after death.

neral Director: After of filled in by the funera Division spital ours a

**Physician** 

/Medical

Examiner

**Funeral** 

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Physician/Medical Examiner

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ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

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Department of Her
Important: If item
any injury or othe

**Physician** 

/Medical

Examiner

traumatic event,

To the Hospital or Attending Physisian of Newhin 24 hours after death.  To the Funeral Director: After this of completely filled in by the funeral director.  Medical Certification: To
- ( ) V X \ 0 1

				1 ☐ Yes 21 ☐ No	1 □Yes 2 □No							
25. Was case referred to medical examiner?	-		26. Place of Dea	ath (Check only one)								
1 Yes 2 No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3 1	OOA Other: 4 Nursing H	g Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manny of Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury oc	courred							
3 ☐ Suicide 6 ☐ Could not b determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, factory)	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
29b. Signature and title of certifier		2	9c. License number	29d. Date si	gned (Month, Day, Year)							
Mahulu	NI 1	10 -	D 60515	11/2	2/09							

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN SHORE DR, SAUSBURY MD 21804 M. 14/Man ANAYA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 37517 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Jelanci Estelle 0545 AM November 5 2009 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hospital Baltimare Baltimore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🖫 F Hours 4-07-8806 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1timore 1 PYes 2 □ No Funeral Director 28a-f 10e. Street and Number 10g. Citizen of What Country? items 23a or USA Vieu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ò 1 □Yes 2 No Completed by If Yes, Give Year or Dates: Specify: Black Injury or other traumatic event, the Medical Exa-3 ₩Widowed 4 □ Divorced natura!" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Someone else 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Molock homas ဥ Delancy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Rollite Number, City or Town, State, Zip Code) Avenue Baltinore, MD, 21215
Date 20c. Location - City or Town, State Department of Heal Important: If item 2 any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/09 Fork Neck Cemetery Vienna, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A. 510 washington St. Cambridge 23a, Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final associated with Complications **Physician** coronani arten disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit be exect Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Mellitus 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Hospital or Attending Physician: The certificate Carcionyo pathy performed 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ie Funeral Director: Affolgelej filled in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the P within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 5, 2009 050693 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar EDPLES

DHMH 17 Rev 1/2001

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32. Registrar's Signature

tospITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NHOVEMBERY 23, YOU 4:30F M Joseph Lloyd Alsop Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 5. Social Security Number 6 Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ F Aug. 1921, Year 1921 Country Director 225-12-4750 rgiñia Usual Residence of Decedent shov "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d Inside City Limits death with the Maryland Director 1 Yes 2 X No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 101 Kenilworth Park Drive Apt. 1-A 21204 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 🖾 Yes 2 🗆 No 1950-If Yes, Give 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: 3 Divorced 4 Divorced 1957 White Year or Dates Injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Veterans Administration Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Heflin Bernard Alsop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Kenilworth Park Drive Apt.1-A Towson, Maryland 21204 Jackie Alsop/ Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State November 24. 1 Burial 2 A Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final f Hysicians RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any record to the cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence off the Hospital or Attending Physician; The law requires that the death certificate be executed CHRONIC OBSTRUCTIVE PULMONARY DISEASE attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Other (specify) Pregnant at time of death the a 1 Yes 2 L Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has e 2 s autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 은 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 DRIVE TOWSON. ER TMOTHY THA 31. Date filed (Month, Day, Year) legistrar's Signature 32.

DHMH 17 Rev 7/2009

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	n/	1. Decedent's Name (First, Middle							<ol><li>Date of Death Month</li></ol>	Day Yea		Time of Death 1046 hrs
edical Examir		Lloyd Clintor							Month November	20, 2009 4c. County of	of Death	10401115
		4a. Facility Name (if not institution 5414 Hildebrand Court	-	nber)	4	b. City, Town, Columbia		of Death		Howard	)f Death	
Funeral				7. Age (In yrs. las	t birthday)	If Under 1 \	ear If Und	er 24Hrs.	8. Date of Birt	rth(MM/DD/YYYY) 9. Birthplace (State or		
Director	- 1	129-66-7115	1X M 2 F	42	2 <sub>Yrs.</sub>	Months D	ays Hour	s Min.	November	4,1967 Foreign South Country America		
any	-	Usual Residence of Decedent  10a. State 10b. County	_	10c. City, T	own or Location	on					1/	0d. Inside City Limits
<b>*</b>		Maryland Howa	rd		Columbia						1	1 Yes 2 X No
Maryland 28a-f show 1 at once.		10e. Street and Number				10f. Zip Cod	e		10	g. Citizen of W		y?
the M a or 2 tified		5414 Hildbrand Co	urt			2	21044			U.S.A	١.	
h with	Funeral	11. Marital Status	Armed Fo	edent Ever in U.S rces?		s Decedent of es, specify Cu			ecify Yes or No- Rican, etc.)		e - America e, etc.	n Indian, Black,
er deat	핊		1 Yes	2 X No	1	Yes 2X	No specify	r.		Specify:	Blá	ack
urs afte		15. Decedent's Education (Spec	or Dates:		16a. Deceden	t's Usual Occi	pation (Give	kind of w		16b. Kind of Bu	usiness/Ind	dustry
72 ho	ompleted	Elementary/Secondary (0-12)	College (1	-4 or 5+)	•	ost of working		i use retir	ea)	Sysco		
within giene.	틦	12 17. Father's Name (First, Middle,	l ant)		Securi	ty Guard		er's Name	(First Middle N	Maiden Surname	e)	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	Lloyd Clinton Aar							olyn Sydr			
D 21 hould nd Me is ma attic ev	P	19a. Informant's Name/Relations! Lloyd C. Bayley	hip (Type, Print) (Father)		19b. Mailing	Address (S Water Fo	treet and Nu	mber or R	tural Route Num er Mar1bo	nber, City or Tov	vn, State, 2 Land 20	Zip Code) 0774
Baltimore, MD pennit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	20a. Method of Disposition	(Tauler)		lace of Dispos	ition (Name o		1	Date	20c. Location		
DOFE ages 1 at of H t: If it	-	1 X Burial 2 Cremation		UIII State	rematory or oth umbia Me		ark	11-2	8-2009	Clarksvi	ille. N	Marvland
Baltimore, permit. Pages I an Department of Her Important: If ite	ł	4 Donation 5 Other Sp 21. Signature of Funeral Service		1 002				_		ral Homes ia, Maryl		
E P P W		23a. Part I. Enter the disease, or	-//		Do not ortent	5555 Twi	n Knoll	s Road	Columb	ia, Maryli	and 210	Approximate Interval
Physician Medical		23a. Part I. Ent <del>er the</del> disease, or failure. List only one cause	on each line.					Cardiaco	respiratory arr	031, 3110011, 01 11		Between Onset and Death
gaminer		Immediate Cause (Final disease or condition resulting in death)		consequence of)		Loacid	USIS					
		Sequentially list conditions,	b	of	۸.						$\overline{}$	
	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.	consequence of								
ig g	Examin	events resulting in death) Last	Due to (or as a	consequence of	):							
O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	Medical	X UNPENDED	AMENDED	23a,27,	ner M	E 0900	2/19	/10-т	T			
760, icate be physic the bur		IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregn	nancy		3 Ecto			23d. Date of Month	-	ay Year
Box 687  e death certific  the attending p  ed for use as th	cian	past 12 months?		nant at time of dea	neth -	etal death ther (Specify)	3	pic progrit	aricy			.,
Boy te deatl the att	Physician/		known 9 Unkn		title e le the		una miuan in	Dort I	23e Did t	obacco use con	tribute to t	the cause of death?
ires that the signed by	by P	Part II. Other significant condit	tions contributing t	o death but not re	suiting in the	underlying car	use given in	raiti.				ably 4 Unknown
ords, F w requires s been sign should be									24a. Was			topsy findings available ompletion of cause of
Recor The law r icate has b page 2 sh	Completed								auto perfo	ormed?	death?	
tal Rectinant The certificate		25. Was case referred to medica	al			26.	Place of Dea					L
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital:		ER/Outpatien				ng Home 5	Residence 6		: Scene
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be railled reference. After this certificate has been signed by the attending physicial birector, page 2 should be detached for use as the burit		27. Manner of Death  1 X Natural 5 Pen		e of Injury h, Day,Year)	28b. Time of		. Injury at W Yes 2		280. Describe	how injury occu	irreu	
Professional Strain Str	icati	2 Accident Inve	estigation 28e Pla	ce of Injury - At ho	ome, farm, stre						nber or Rur	ral Route Number, City
Division of Vital   Hospital or Attending Physician: Future after death Future after death et printed Director: After this certificity filled in by the funeral director,	Certification:		ld not be ermined (Specify	)					or Town,	State)		
//W \$4 = 5		29a. Certifier 1 Certifying P	hysician: To the beaminer:On the basis	est of my knowledg of examination a	ge, death occu nd/or investiga	urred at the tin ation, in my op	ne, date and iinion, death	place, and occurred	d due to the cau at the time, date	ise(s) and manr e and place, and	ier as state d due to the	e cause(s)
To the I To the Complete	Medical	29b. Signature and title of certifi	and manner	stated.			icense numb					nth, Day, Year)
		Mayena	Melshu	l			D.C.M.E.			Novembe	∍r 21, 20	)09
		30. Name and address of person Margarita Korell MD.		use of death (Item edical Examin	123a) ner 111 F	Penn Stree	t, Baltimo	ore, MD	21201			
	tate			egistrar's Signatu								
Regis			4 2nng   2	Euro	1. 4	e del						
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State of Maryland / Department of Health and Mental Hygiene 2009 37520 for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6: 30P M **Physician** Margaret Patricia Anderson November 18 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Lothian 5978 Little Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sept. 13,1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2 F 215-09-0507 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Invalid Eron. 1 ☐ Yes 2 🕅 No Funeral Director Lothian MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20711 5978 Little Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🚻 No White Specify: Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Margaret McGonigle George Augustus Durst ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5978 Little Road Lothian Maryland 20711 Mr. Thomas Anderson /Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 23, 2009 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician ARTERY DISEASE CORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) Aner mis certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical соmpletely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) 8661 Veterans No 31. Date filed (Month, Day, Jear) 32. Registrar's Signature State NU

ORIGINAL

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Registrar

09-09007 Catherine Brouse Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 37521

adicinic L	310030		For State Certificate of Death	Reg. No.
Ph	ysicia		. Decedent's Name (First, Middle,Last)	onth Day 2000 2345 hrs
ledical E		1er		nonth Day Year 2345 hrs ovember 19, 2009  4c. County of Death
		4	Ia. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Lippor Chesaneak Medical Center  Bel Air	Harford
			Opper Oncoupeak medical College	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
	neral ector		Months Days Hours Min.	Oct. 17,1969 New Jersey
	any		Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
_	≩		MD Baltimore Dundalk	1 Yes 2 X No
rylanc	28a-f show 1 at once.	황	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
he Ma	23a or 28a-f sho notified at once	Director	223 Pinewood Road 21222	United States
with t	ns 23g	ᇹ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.
5 72 hours after death with the Maryland	or iter	Fune	Never Married 2 X Married 1 Yes 2 X No	Specify: White
after	iner.	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work	7 17
hours	'natural". Examiner		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4 or 5+)	
36 hin 72	than edic l	휥	12 Years 2 Years Registered Nurse	Provider
5-0036 led within	2 4 2	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (Fir	rst, Middle, Maiden Surname)
Σ. ₩ 🖥	E 25 ±	8	Howard Webb	istina Clifton
MD 21 2 should	is ms	욘	19a. Informant's Name/Relationship (Type, Print)  Mr. Brian N. Brouse (Husband)  19b. Mailing Address (Street and Number or Rura  223 Pinewood Road Du	
, MD and 2 sho	ealth g	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery, D	ate 20c. Location - City or Town, State
Baltimore,	: If it	1	1 Seurial 2 Cremation 3 Removal from State crematory or other place) Holly Hill Mem. Gdns. 11/2	24/2009 Middle River, MD
it. Pa	rtmen ortant		Donation 5 Other Specify:  21. Sanature of Funeral Service Ligensee  22. Name and Address of Facility Duda-Ruck Funeral Ho	
Ba Perm	Department of Health and Ment Important: If item 27 is mark injury or other traumatic ever		7 7922 Wise Ave. Dun	dalk, Maryland 21222
Phys	ician		23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arrest, shock, or heart Approximate Interval Between Onset and
	dical miner		Immediate Cause (Final disease a. Multiple Injuries	Death
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760, cate be executed	physician and the burial - transit	Medical	UNPENDED AMENDED	
<b>'60,</b>	physic he buri		IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery  Month Day Year
Sion of Vital Records, P.O. Box 687	After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as t	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify)	y World Bay 1868.
30X leath o	e atter	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	
O. E	l by th tached	표	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
o. th	signec be de	d by		
rds	been should	lete		24a. Was an autopsy prior to completion of cause of death?
ecc he lav	ate has	Completed		1 ✓ Yes 2 No 1 ✓ Yes 2 No
<u>=</u> =	ertific ctor, p	BeC	25. Was case referred to medical 26.Place of Death (Check on	
Vit.	this c Il dire	10 E	1 ✓ Yes 2 No	Home 5 Residence 6 Other:
of Ing P	After	Ë	27. Manner of Death (Month 2000 Park of No. 2012 hrs. 2012 hrs. 2012 hrs. 2014 hrs. 20	redestrian struck by autos
SiOT	after death.  Director: d in by the	gţi	5 Felicing	28f. Location (Street and Number or Rural Route Number, City
	s after Il Dire ed in b	Certification:	3 Suicide 6 Could not be determined (Specify) 1 ocal Street	or Town, State) tt. 136 1/2 mile N. of Schucks Rd., Bel Air, MD
Divi	within 24 hours after death.  To the Funeral Director: completely filled in by the		29a. Certifier A Contifuer Physician. To the best of my knowledge, death occurred at the time, date and place, and d	lue to the cause(s) and manner as stated.
10 =	thin 24 the F	Medical	(Check colly 1 Certifying Physiciati. To the best of in kindindegs, death or investigation, in my opinion, death occurred at and manner stated.	the time, date and place, and due to the cause(s)
T <sub>o</sub>	.™ To	₹ S	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
			( ) ( profolety) O.C.M.E.	November 20, 2009
		1	30. Hame and address of person who completed cause of death (Item 23a)	
		1		11
			Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120  31. Date filed (Month, Day, Year) 32. Registrar's Signature	11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 109 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** NO 2009 10:15 pm /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 11522 EASTERN AVE BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Yrs. 92 MARYLAND Director SEPT 30, 1917 213-26-0686 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 XXVo Director MARYLAND BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number U.S.A by Funeral 11522 EASTERN AVENUE 21220 death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 XXIVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2**XXX**No Specify Specify: BLACK 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Fages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Its Manay injury i Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CO SCHOOLS 12th grade SUB TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ JAMES H. VENEY RINGOLIA VENEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Golden M. Beasley-Watters/Daug. 11522 EAstern AVe., Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHARP STREET U.M.C. :11-30-09 CHASE, MARYLAND 21. Signature of Eurofal 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. MOLLICO 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part 1. Envir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical N/A
3 Ectopic pregnancy IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.0. 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performe 1 Yes 2 No NIA certificate 1 ☐ Yes 2 ☑ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

For

			Registrar	"IO LEL	rii Goyo	14Cer	Hifticate of	Death		Reg. No.		0,020
			1. Decedent's Name (First, Middle, La	st)					2. Date of Month	Death Day	Year	3. Time of Death
	Physicia /Medic		IRENE E	UZREI					Nov		2009	12:40 AM
	Examin		4a. Facility Name (If not institution, give	e street and nu	mber)		4b. City, Town, c	r Location of [	Death	4c. Count	y of Death	•
فمرسد			UNIVERSITY OF MARY	LAND ME	DICAL	SALVE	BALTI	LOIZE				
	Funeral		Social Security Number 6. 9		7. Age (In yrs. I	ast birthday)	If Under 1 Year		Hrs. 8. Date of	Birth	9. Birthp	lace (State or Foreign
	Director		218-28-8155	ı□м 21□ F	76	Yrs.	Months Days	Hours	Min. (Month,	Birth Day, Year) 24-1933	Coun	MD
	D		Usual Residence of Decedent	1								
	ylan how		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mar a-fs	ᅙ	MD n/a			Baltimo	re					Y☐Yes 2☐No
	r 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	itry?
	13a c	a D	1012 N. Payson Street	t			21	217		i	ISA	
	deat ms	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V	Vas Decedent of I	lispanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra	ace - Americ	
٥	after or ite		1 ☐ Never Married 2 🕅 Married	Armed Fo 1 ☐ Yes If Yes, Gi	2 X No		ires, specily Cub I⊡Yes 2X☐No		rueno nican, etc.)	1	ack, White,	an-American
9500-91212	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examination of the confiled at	t by	3 Widowed 4 Divorced	Year or D	ve ates:		LL Tes ZALINO	эреспу.		Spec	IIYX ILL L	201 / 11K.L.1201
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7	d wi	5	12th			Mach	iine Operat			London I		ustries
B		Be (	17. Father's Name (First, Middle, Last	")				18 Mother's	Name (First, Mid	dle, Maiden Surna CCI	ime)	
Maryiand		2	Charles Hillery					Cloria	Carter	Geneva	Carte	r
a	2 should be and Menta is marked aumatic ev	ľ	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Number	or Rural Route Nu	mber, City or Tow	n, State, Zip	Code)
	rt 2		Deborah L. Harris/ D	angliter		1012	N.Payson S	treet, E	Baltimore, 1	MD ZIZI/		
o)	Stal		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	wn, State
Baitimore,	permit. Pages 'Department of H Important: If ite any Injury or of once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci				rial Park	11-	-2809	Arbutus	, M -	
	mit.	1	21. Sign, ture of Funeral Service Lice		1 .	22	. Name and Addre	ess of Facility	Whie Fune	rai Hore P	A. of	Balto. Co.
ñ	any per		* Marega 1	1.18le/	(x)	92	00 Liberty	Road, 3	Randalistow	n, MD 2113	3	
			23a. Part. Enter the disease, or con	plications that	caused the death	n. Do not ent	er the mode of dyi	ng, such as ca	ardiac or respirator	y arrest,		Approximate
	Neveleion		shock, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death
94	hysician /Medical		disease or condition resulting in death)	- CA.	(or as a consequ	ionno ofi:					_	2 DAYS
A. S.	Examiner			Due to	(or as a consequ	derice oi).						
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):						
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
	exec	Xa	resulting in death) Last	c Due to	(or as a consequ	uence of):					_	
ತ .	e be sicia buri			. d								
6876U,	n certificate be executed anding physician and use as the burial-transit	n/Medical		u								
	nding nding use a	N.	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna					23d. D	Date of deliv	ery
ň	leath atte	cia	in the past 12 months? 1 □ Yes 2 No		birth 2  Feta Feta Feta Feta		Ectopic pregnan Other (specify)	СУ			Month	Day Year
j .	the c y the chec	Physician	9 Unknown	9 🗌 Unki	nown		,, ,,					
7	w requires that the death s been signed by the atter should be detached for t	P	Part II. Other significant conditions	contributing to d	leath but not resu	ulting in the ur	nderlying cause gi	ven in Part I.	23e. D	id tobacco use co	ntribute to t	he cause of death?
Hecords,	uires n sigr Id be	d by	CHRONIC TENA	Z FAIL	いえぎ				1	☐Yes 2☐No	3□ Pro	bably 4 Unknown
<u></u>	v req beer shou	Completed			_				240 V	Vas an 24t	Wore auto	opsy findings available
۳	(C) 150 (D)	ם	PERIPHETZAL V	ASCULA	R DISE	ASE			l a	utopsv l	prior to co death?	empletion of cause of
_ 	sician; The law s certificate has t lrector, page 2 s								1 □ Ye	erformed? es 2 No	1 ☐ Yes	2 🗆 No
VItal	Iclar certif ector	æ	25. Was case referred to medical examiner?	Hospital:				26. Place o	of Death (Check or	nly one)		
0	Phys this al dir	P	1 Yes 2 No		Inpatient 2		IL 3 LI DOA	4 Li Nurs	sing Home 5 F			fy)
<u> </u>	ing After	lo O	27. Manner of Death  1 Natural 5 ☐ Pending	1 '	nth, Day, Year)	28b. Time of Injury	Wo			ibe how injury occ	urrea	
S	tend leath tor: ,	cat	2 Accident investigation 3 Suicide 6 Could not be					]Yes 2 □ N				
DIVISION	or At fter o pirect in by	Certification:	4 Homicide determined	28e. Place build	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28t. Location	on (Street and Nur Town, State)	mber or Rur	al Houte Number,
	urs a ral c											
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the	basis of examina				I place, and due to n occurred at the ti			
	the the the mple	Med	one)	and mar	nner stated.		000 1/2	00 01/00		204 D-1	nod (Manth	May Vaarl
	<b>5</b> € §		29b. Signature and title of certifier		>.			se number	. 0.1	29d. Date sign		_
			> sulle	~	MD		134	1475	191	Nov.	20,2	007
			30. Name and address of person who									
			SARAH GOLDBEI	- 13		CREE	ME ST.	, BAL	TIMORE,	MD 212	10	
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ture	D					
	Registr	ar	MUY & 4 ZUUS	perm	D B. 1	STORE .						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37524 Reg. No 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 519 Physician AM Paul J. Britt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Hours | Min. | Month Pay, Y Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Feb. 1 1 M 2 □ F 214-44-0545 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2X No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 208 Robwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 157 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 🛣 No Specify. þ Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene, important: if item 27 is marked other than "ns any injury or other traumatic event, in Media Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Baltimore City 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rita Manley Lacey Britt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carrie Britt /daughter 9743 Chapel Road Easton 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Date 20a. Method of Disposition **★** Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/09 Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Funéral 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or Commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Partial small bowel obstruction with possible ischemic bowe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Hunknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed physician and Division of Vital Records, P.O. Box 68760 ģ After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. the

buriai-trar the funeral

aftending for use as signed by

28a-f show

ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the "Redical Experimer must be notified at

3altimore, Maryland 21215-0036

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 237784 munch

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

9000 Franklin Square Frenc Baltimore, MD 21237 Dr. GINNY 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a, Certifier (Check only one)



09-09046 Matthew Burgess

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 37525

attion Bongood			tificate of	Death				g. No.	To The of Dooth																
Physician edical Examine	1 1	ngistrar Decedent's Name (First, Middle,Last)  Matthew	Burges	s			Date of Deat Month <b>Jovembe</b> r	Day 2009 Ye	3. Time of Death 0240 hrs																
euicai Examin		a. Facility Name (if not institution, give street and number)  Harbor Hospital	4	b. City, Town, or Baltimore	Location of	Death		4c. County	of Death																
Funeral Director	5	. Social Security Number 161 – 60 – 7715 6. Sex 7. Age (in yrs. la	st birthday) Yrs.	If Under 1 Year Months Day		_	3. Date of Bir 18/03/		9. Birthplace (State or Foreign Country)																
d now any	1	Sual Residence of Decedent  10a. State 10b. County 10c. City,  MD Anne Arundel	10d. Inside City Limits 1 Yes 2 X No																						
ne Maryland or 28a-f show fied at once.	Director	0e. Street and Number 1011 Stane Road		10f. Zip Code 2106	50		1	USA																	
death with 1 or items 23s	Funeral	1. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Y	s Decedent of Hes, specify Cubs	an, Mexican,	in? ( Speci Puerto Ric	ify Yes or No can, etc.)		ice - American Indian, Black, nite, etc. y. White																
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  Itant: If item 27 is marked other than "matural", or other traumatic event, the Medical Examiner.	mpleted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Deceden during m	nt's Usual Occup lost of working lit	fe. DO NOT	ind of wor use retired	k done		Business/Industry																
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than injury or other traumatic event, the Medical		17. Father's Name (First, Middle, Last)  Lawrence Gannon Burges	ss		De!	borah	ı Ann																		
MD 212 nd 2 should b alth and Meni m 27 is marl	T <sub>O</sub>	19a. Informant's Name/Relationship (Type, Print) Brandie L. Burgess / Wife	1234	Colon	ial D	rive,	ral Route Nu Seve	rn, MD	Town, State, Zip Code) 21144 on - City or Town, State																
Baltimore, Normit, Pages I and Department of Healt Important: If item injury or other trau		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:	dbine, MD																						
Baltie permit. 1 Departm Importa injury o	1	21 Signature of Funeral Service Licensee Dorota Marsh	nall 22.	Mary L PO Bo	and C x 141	rema 3, E	ation Balti	Servi	Ces MD 21203																
Physician /Modical caminer		23a. Part i. Enter the disease, or complications that caused the death failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of the cons		the mode of dyir	ng, such as c	ardiac or r	теѕрітацогу а	mest, snock, or	Between Onset and Death																
	Examiner	cause. Enter Underlying Cause																							
xecuted n and transit		events resulting in death) Last d.	of):																						
760, cate be exphysician the burial	ician/Medical	sician/Medic	sician/	sician/	sician/Medic	sician/Medic	sician/Medic	sician/Medic	sician	sician/	sician/	sician/	sician/	sician/	sician/	sician/Medic	sician/	UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  23c. If yes, outcome of pre	2 F	Fetal death Other (Specify)	3 Ectop	ic pregnar	ncy	23d. Dai Mon	te of delivery th Day Year
P.O. Bc that the der med by the a detached fo	by Phy	Part II. Other significant conditions contributing to death but not	contribute to the cause of death?  3 Probably 4 Unknow																						
Division of Vital Records, P.O. Box 68.  To the Hospital or Attending Physician: The law requires that the death certificate death the formula after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed							24a. Was an autopsy performed?  ✓ Yes 2 No 24b. Were autopsy findings of completion of condeath?  1 ✓ Yes 2 No 2																	
l Re n: Th riffical or, pa	ပ္တို	25. Was case referred to medical		26.P	ace of Deat	h (Check o	only one)																		
Vita ysicia his cer direct	To Be	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2	✓ ER/Outpatie		Other <sub>4</sub>		g Home 5	Residence be how injury o																	
on of variance of the control of the	tion: T	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year) Nov 21, 2009	28b. Time o 0201 hrs	1	Injury at Wo	No	Pedestria	ın struck by	auto																
Division tallor and the control of t	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State) West Ordance Rd & Roberts of Specify) Wast Ordance Rd & Roberts of Specify (Specify) Major Road / Highway																							
Division of Vital I  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowl one) 2 Medical Examiner: On the basis of examination and manner stated.	edge, death oc n and/or investi	curred at the tim gation, in my op	e, date and pinion, death	place, and occurred a	due to the o	ate and place,	and dde to and odds-(-)																
witi v	Med	29b - Brignature and title of certifier)	080	1	cense number	er			e signed (Month, Day, Year) nber 21, 2009																
		30. Name and address of person who completed cause of death (It Victor Weedn MD JD Assistant Medical Exar	tem 23a) miner 111	l Penn Stree	et, Baltimo	ore, MD	21201																		
S Regis	state stra	31. Date filed (Month, Day, Year) 32. Redistrar's Sign	nature A.	barker																					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IOMORTH BERDAYES, Year 212 Μ. Elizabeth Bennett 219:13A Medical 4c. County of Beath timore 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Hours 80 Apr 30, Year) 929 220-20-1644 Maryland Director Usual Residence of Deceden 28a-f shov 10a, State 10b. County "natural", or items 23a or 28a-f sho adical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Directo MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A. 8800 Walther Blvd #2010 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Secretary other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nettie Tabor of Health and Mental I fitem 27 is marked o Joseph John Muller Nettie traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd, #2010 Parkville, MD Allen A. Bennett-husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Hamportant; If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment Moreland Mem. Garden 11/28/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician OSTEOMYELITIS VERTEBRAL BODIES disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EXTENSIVE INFECTION OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events AORTO-BIFEMORAL GRAFT and-tran Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical SEVERE PERIPHERAL VASCULAR DISEASE Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month the detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 23e. Did tobacco use contribute to the cause of death? 9 ACUTE RENAL FAILURE of Vital Records, 2 No Completed 1 Yes 3 Probably 4 Unknown peen HYPERKALEMIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ဂ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place in by the funeral completed filled in the funeral completed filled fill Natural 5 Pending work? Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ceptifie 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 TIMOTHY LOW. M. D. OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Barphil

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Hospice timore If Unde 6. Sex Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 Months **Director** 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c . City, Town or Location 10d. Inside City Limits Director 1 Dres 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes Civo Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) ollege (1-4 or 5+) Be 17. Father's Name (First, Middle, Last r's Name (First, Middle, <u>Ma</u>iden Sui ၉ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 20, 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, NOVEMBER Method of Disposition 20b. Place of Disposition (Nat 20c. Location - City or Town, Star Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HELENA BAILEY 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 🗶 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1X Natural (Month, Day, Year) injury 5 Pending Division within 24 hours after death.

To the Funeral Director: Af death. 1 🗆 Yes 2 🗆 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tle of 29c. License numbe 29d. Date signed Month, Day, Year) 009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOY 24 Registrar

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AMEND ITEM#5.17, 18perFH, G898, 12/2/09, WS
State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, 2009 8:30 A M PEARL November BAKER RESONA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1611 Michelle Court Apt. C Forest Hill If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5 Social Security Number 227-28-4104 277-28-4104 **Funeral** Days Hours 1 □ M 2 1 F 84 1925 Kentucky Director April 4, Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tru Medical Examiner must be redified at 1 ☐ Yes 21 No **Funeral Director** Forest Hill Maryland | Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21050 1611 Michelle Court, Apt. C 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 An Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aha (nmn) Bolling Dennis Elmer Mullins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1611 Michelle Court, Apt. C, Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health ar J.D. Baker / Spouse Department of Health Important: If item 27 any injury or other trong. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/09 Fallston, Maryland Highview Mem. Gdns. 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 20year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Vause (Unsease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): physician Box 68760 attending ph nse : IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown s been signal 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 0 ron has page 2 autopsy certificate 1 Yes or Attending Physician: After this certific funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes No Other: 4 Nursing Home 5 Kasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, pay, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nurrisville Rel James Hsville -WAC 31. Date filed (Month, Day, State NOV 2 4 2009 Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			4a. Facility Name (if not Johns Hopkins		street and numbe	r)	41	o. City, Town, o Baltimore	r Location of De	atn		4c. County	or Death		1	
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MD d 2 short	nent of Health and Mental Hygiene. 	_	Alethia B			er)	451 N	orth I	Ellwood					D 21224		
re, l	f Heal If item er tra		20a. Method of Dispositi	ion Cremation 3	Removal from S		ce of Disposit	tion (Name of co er place)	emetery,	Date	20	c. Location	n - City or 1	Fown, State		
Baltimore,			4 Donation 5	Other Specify:				el Cen			/09 B					
<b>Ball</b>	Depart Impor injury	N 78	21. Signature of Funeral	I Service Licens	ee / /1 //	Main	22 No	me and Addre	S of Facility Brov	wn J:	r. Fu	nera	1 Hom	e MD 21217	,	
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	edical miner	1	failure. List only or Immediate Cause (Final	I disease a.	Gunshot woun	nd to the hea	ad						55	Death	_	
			or condition resulting in death)  Due to (or as a consequence of):													
		ner	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):													
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<b>60,</b> ate be e	nysician burial	Medical	IF FEMALE:	IF FEMALE: 23c. If yes, outcome of pregnancy								23d. Date	of delivery		$\dashv$	
687 ertifica	e attending phy for use as the b	an/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant								ancy Month Day Year					
Box 687	e atten I for us	Physician/	4 Pregnant at time of death 5 Other (Specify) 9 Unknown													
O. E	ned by the detached f		Part II. Other significar	2	23e. Did tobacco use contribute to the cause of											
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Rec	ficate }	Con									✓ Yes 2		1 🗸 Ye	s 2 No	_	
/ital	r this certificate h al director, page 2	Be	25. Was case referred to examiner?	, Н	ospital: 1 Inpa	tient 2 🗸 EF	R/Outpatient		Other Nu	eck only or ursing Hom		sidence 6	Other	·		
of V	After th funeral o	n: To	1 ✓ Yes 2 27. Manner of Death	No	28a. Date of I	njury 28	8b. Time of Ir		jury at Work?	28d. I	Describe hov	v injury occ	urred			
ion	leath. tor: A	atio	1 Natural 5 2 Accident	Pending Investigation	Nov 20, 200	09 2	118 hrs	1	Yes 2 V No		ect shot					
Division	hours after death ineral Director; y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street								ocation (Street or Town, State McElderry	0)		ral Route Number, Ci	ity	
lospita	24 hours after death Funeral Director; tely filled in by the		4 ✓ Homicide 29a. Certifier 1 Certi		an: To the best of	ocal Street	death occurr	red at the time.	date and place.						$\dashv$	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 h To the Fur completely	Medical	(Check only 1 Centrone) 2 Med	lical Examiner:	On the basis of ex	xamination and/	or investigati	on, in my opinio	on, death occurr	ed at the ti	ime, date and	d place, an	d due to th	e cause(s)		
<b>Λ</b> F	≱ <b>⊢</b> ర	Me	29b Signature and title				1		nse number					nth, Day, Year)		
			(all	11	M		1	, 0.0	C.M.E.			Novemb	er 21, 2(	J08	_	
			30. Name and address of Zabiullah Ali, M		ompleted cause of tant Medical			n Street, Ba	ltimore, MD	21201						
	St	tate				trar's Signature										
	Regis	trar	71(	14 2 4 2	009 2	www.	B. Jan	replas	<del></del>							

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 2356 Rosalie E. Burkhead 2009 November 17 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Vear | If Under 24 Hrs. Hospita Hones Social Security Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Hours Days Months 1 □ M 2 🕅 F 218-32-9207 March 30,1938 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2X No Balto. Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7819 Shepherd Avenue 21234 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☐ MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Smith, Sr. Genevieve Sieracki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR. 5405 Creston Lane Deborah L. Kairos Balto. Md. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 11-23-2009 Moreland Memorial Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final twelve hours disease or condition resulting in death) Due to or as a consequence of): four hours Hyperhalemia ue to (ras a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nown ilable

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Be Completed

Medical Certification: To

Md.

**Funeral** 

Director

show

d other than "natural", or Items 23a or 28a-f shovevent, the find cal Examiner is ust by notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 4.4 hours after death. and burial-trai physician the attending p this certificate

Records, P.O. Box 68760,

within 24 hours after deat To the Funeral Director;

Ovarian	Canier	Renal fai	lure	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆	<del>] U</del> nk
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	
25. Was case referred to medical	/		26. Place of De	ath (Check only one)	
examiner?	Hospital: 1 Impatient 2 II	ER/Outpatient 3 🗆 [	DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manney of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Locetion (Street and Number or Rural Route Nu City or Town, State)	ımber
				ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause	e(s)

29c. License number

319914795

Bultmore.

29d. Date signed (Month, Day, Year)

4 anyland 21229

November 17, 2009

State Registrar

31. Date file (Month, Day, Year)

Check les

MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Meghan

900 S. Caton Avenue 32. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 18,2009 Physician Mary Boyd Frances November 7:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 214 Nashua Court Anne Arundel Gambrills If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace *(State or Foreign Country)* Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Day, Year) 6,1951 1 □ M 2 🖔 F 214-58-6136 57 Dec. Director Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland thit and Mental Hyglene.
?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Estimither mant to refilled at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Co. Gambrills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21054 214 Nashua Court Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 🗖 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College\_(1-4or 5+) Registered Nurse Healthcare yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew John Kalb, Jr. Genevieve Theresa Zakrzewski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nt of Health a t: If item 27 is y or other trai Mr. William E. Boyd /Husband 214 Nashua Court Gambrills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If any Injury or once. 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Atlantic Crematory 11/20/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility  $Singleton\ Funeral\ \&\ Cremation$ 21. Signature of Funeral Service Licer M01121 Services PA; 2nd Ave SW; Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Adenocarcinoma 2 years disease or condition resulting in death) 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🖽 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To after death.

I Director: After this d in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

within 24 hours a

State Registrar 29b. Signature and title of certifier

JoMahony

malion

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

STPaul

046389

Bultimore, MD 21202

29d. Date signed (Month, Day, Year)

November 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, &

		_ State			2005	37533						
		1. Decedent's Name (First, Middle, Last)	- Douis		10.	3. Time of Death						
Physicia		Joseph Anthony Bartell, Sr.		Month D								
/Medica		4a. Facility Name (If not institution, give street and number)	4h City Town or Location of Death		$\overline{}$							
Examine	er	Casey House										
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9 Rint	nplace (State or Foreign						
Director		220-30-4029 1♥M 2□ F 74 Yrs	Months Days Hours Min.	01-01-193	5 Vir							
P .		Usual Residence of Decedent			· · · · · · · · · · · · · · · · · · ·							
show	١											
Ba-f s	Director											
or 2	ä	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Co	untry?						
ath w	a.	12350 Point View Road	2. Date of Death Month November 20, 2009   3:05 AM									
er de items	Funeral		<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecity Yes or No- Rican, etc.)		3. Time of Death 3:05 AM  ounty of Death  Montgomery  9. Birthplace (State or Foreign Country) Virginia  10d. Inside City Limits 1						
rs aft	by F	1 ☐ Never Married 2 🕱 Married 1 ☐ Yes 2 🖼 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🛛 No Specify:		Specify:	White						
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othe vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	en Surname)							
Tand 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.  em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examinar must be notified at	2	Joseph A. Bartell	Sophie	Rubashaevs	ky							
and I	•	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number or Rur	al Route Number, City	y or Town, State, 2	(ip Code)						
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of He		20a. Method of Disposition  20b. Place of Discemetery, or Commentary, or Commenta	sposition (Name of rematory or other place)	Date 20c.	Location - City or	Fown, State						
Pagrant: I		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Catl	nedral Cemetery 11-									
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ones.		21. Signature of Funeral Service Lieunsee	·									
	7					Approximate						
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/Medical		disease or condition resulting in death)  a.   GdS LFOTTLES LTrd1  Due to (or as a consequence of):	breeding									
Examiner		Metastatic Lung Cancer										
70 +	ner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of):										
be executed ician and burial-transit	Examiner	that initiated events c.										
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at or s afte i Dire	Certification: To	4 ☐ Hornicide building, etc. (Specify)		City or Town, Sta	ate)							
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the H hin 24 the F	Medical	one) and manner stated.	1									
or with	2	29b. Signature and title of certifier	29c. License number	290.1	Date signed (Mont	n, Day, Year)						
			100,40	Nov	ember 20	2,2009						
8		30. Name and address of person who completed cause of death (Item 23a) (Type 1 and 1	pe, Print)	11.11000	n =							
* Stat	0	31. Date filed (Month, Day, Year) 32 Registrar's Signature	GOEI NUNCASTEC/	4111 Ka.	Dockulle,	MD 20853						
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		Maria and Mountain										

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22, Boutilier 2009 Mary Ρ. November 7:42 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Genesis Eldercare Layhill Center Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 86 508-18-1847 **Director** Nebraska April 19,1923 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and by nothing at Director MD Silver Spring 1 ☐ Yes XX No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. 15107 Interlachen Dr. 2 - 21120906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 Yes, Give 2 □ No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd Viola Messman Pope ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) 15107 Interlachen Dr. 2-211, Silver Spring, MD Ronald C. Boutilier / Husband Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 11/24/2009 Beltsville, MD 4 □ Donation 15 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 21. Signature of Funeral Service L. MO0382 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 ☐Yes 2 ☐No Physician: 25. Was case referred to medical examiner? 26. Plac of Death (Check only one) Be Other: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated To the Pwithin 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saadia Husain 31. Date filed (Month, Day, Year) State May 24 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37535 Reg. No. 2009 Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) COOPER OLIVER 9:35 A M Physician November 2009 20 /Medical 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. or ce (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. Funeral Days 1 M 2 □ F Director Usua Residence of Decedent nside City Limits 10b. County 10c. City.∕Town or Losation show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "nected Examinar must be rectified at 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? 10f Zin Code death with Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Vsual Occupation (Give kind of work done during most of working kife. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Las permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item ZZ Is marked oth any Injury or other traumatic eveni once. Be ဥ State, Zip Code) 20b. Place of Disposition cometery cremator Method of Disposition 1 Burial Cremation 3 Removal from State 5 ☐ Other (Specify) 4 □ Donation Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myelogenic Chromic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician the burial Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physician; after death. 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospina. ... within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Resident, Payi November; 20, 2009 RES OOI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001, South Hanover Street, Baitimore, Maryland, 21225, Dr. Mahdis Sarraf,

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

09-08864 Charles Collins

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2009 37536

		- 1	1- For State Registrar				Ce	ertifica	ite of i	Death					Reg. No.	20	0 3	
Phy	/sicia		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year															
edical Ex	camiı	ner	Charles Henry Collins, Jr. November 15, 2009												J55 hrs			
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death															
,			Peninsula F	Regional N	1edical (	Center				Salisbu	iry				Wicomico			
Fun	eral		5. Social Security I	lumber	6. Sex		7. Age (In yrs.	. last birth	iday)	If Under	1 Year	If Under	_	8. Date of E	Birth(MM/DD/			e (State or
Dire			213-80-	9068	1 M	2F	49		Yrs.	Months	Days	Hours	Min.	05/05	5/1960	Fore	Country	Maryland
	-	}	Usual Residence of	f Decedent	X					<u> </u>								
	ny	ŀ	10a. State	10b. County			10c. Cit	ty, Town o	or Locatio	n							10d.	Inside City Limits
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ylanc	onc onc	힕	10e. Street and Number							10f. Zip C	ode				10g. Citizen	of What Co	nuntry?	
Mar	r 288	Director	422 Banks Street							21851						J.S.A.		
h the	or items 23a or 28a-f show any must be notified at once																	
h wit	b r	Funeral	11. Marital Status			<ol><li>Was Dec Armed Fe</li></ol>		U.S.		Decedent s, specify				cify Yes or Nican, etc.)		Race - Am White, etc.		ndian, Black,
deat	or ite	اڃ	1 Never Marri	ed 2N	narried 1	Yes	2 X No											
after		à	3 Widowed	4 X Di	vorced If Y	Yes, Give Yea Dates:	r			Yes 2X						ecify: B1		
ours	"natural",		15. Decedent's E	ducation (Sp	ecify only b	highest grad	de completed)			s Usual O st of worki					16b. Kind	of Busines	s/Indus	ry
<b>69</b>	E S	ompleted	Elementary/Sec	ondary (0-12		College (1	-4 or 5+)		•		-							
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5-0 led w	othe the h	ပိ	17. Father's Name	(First, Middle	e, Last)						18		•		, Maiden Sur	name)		
21215-0036 uld be filed within 7 Mental Hygiene	rked rat,	Be	Charles	Henry	7 Col	lins,	Sr.							la Bi				
	iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	2	19a. Informant's N												umber, City o			Code)
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l and I leal	i tra		20a. Method of Dis			D				tion (Name	of ceme	etery,		Date	20c. Loca	Location - City or Town, State		
no ages ant of	# # E		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Ardent Cremation Services 11/23/2009									9 Han	over.	Ma	rvland			
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/Med		J	failure. List or		e on each	line.											В	etween Onset and Death
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		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated															
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3ox 68760, death certificate be executed	physician and the burial - transit		77		d					_								
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<b>8760,</b> ifficate be	phys	₩.	IF FEMALE:	progrant in		23c. If yes,	outcome of pr	egnancy							23d. D	ate of deliv		
68 Pertifi	ding se as		23b. Was deceden past 12 month		ine		oirth nant at time of					Ectopic	pregnan	су	Mo	onth	Day	Year
Box re death c	atter for us	Sic	1 Yes 2	No 9 U	nknown	g Unkn		death 5	Oth	ner (Speci	<i>fy)</i>							
- u	ned by the attending phy detached for use as the	Physicia	Part II. Other sign	ificant cond			o death but no	ot resulting	in the u	nderlyina (	cause di	ven in Pa	rt I.	23e. Di	tobacco use	contribute	to the	cause of death?
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Die on	an sig	eq	<u> </u>											24a. W	as an I	24h Were	autons	y findings available
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F 12	rtific lor, p	O	25. Was case refe	rred to medic	al					2	6.Place	of Death	(Check or	nly one)				
of Vital Records	After this certificate has been signed by funeral director, page 2 should be detach	20	examiner?	2 No	Hos	pital: 1	Inpatient 2	✓ ER/O	utpatient	3 DC	DA C	Other:	Nursing	Home 5	Residence	e 6 O	ther:	
of of	fter tl	To	27. Manner of Dea			28a. Date	of Injury	28b.	Time of Ir	njury 2	Bc. Injury	at Work	? 2	28d. Descri	e how injury	occurred	-	
		ion	1 X Natural	5 Pe	nding	(Mont	n, Day,Year)				1 Y	es 2	No					
iSiC Atte	ecto by th	ical	2 Accident		estigation	28e. Plac	ce of Injury - A	t home, fa	arm. stree	et. factory.	office bu	uilding, et	c. 2	28f. Locatio	n (Street and	Number or	r Rural F	Route Number, City
Division tal or Attendii rs after death.	ed in	Certification:	3 Suicide		uld not be ermined	(Specify								or Tow	n, State)			
Hospital 24 hours	ly fill		4 Homicide 29a. Certifier	Cortifuing	Physician	1	st of my knowl	lodge do:	oth occur	red at the	time dat	e and pla	ce and c	tue to the c	ause(s) and n	nanner as	stated.	
he H	To the Funeral Director: completely filled in by the	ical	(Check only one)	Medical Ex	aminer: O	n the basis	of examination	n and/or i	nvestigati	ion, in my	opinion,	death oc	curred at	the time, da	ate and place	, and due t	o the ca	use(s)
To t	Com	Medical	29b. Signature an		aı	nd manner:	stated.					number				te signed (		
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			Carol Allan							Street, E		ne, MD	2 1201					
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23: 28 M Mary E. Copes 11 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Balto. Union Mem. Hosp. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 □X Director 10-17-1934 N.C. 212-60-7408 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Wedical Examiner count be notified at 1 ¥ Yes 2 No Director Md Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with ō U.S.A 21202 1732 N. Alsquith St. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2 □XNo Specify. ģ Specify: 3 ₩idowed 4 Divorced Black natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Employed** Dry Cleaning 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Thomas D. Williams Viola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 4346 Shamrock Ave. Balto. Md 21206 Mildred Copes- daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-16-09 Balto. Md Greenmount Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chatman-Harris F.H 4210 en 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End stage renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Diabetes attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. ed by the detached sign**e**d h 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 🖺 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 2009 2432946 86 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice Leahy Memorical Onion Hospita 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician (1) am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner a 8. Date of Birth (Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex If Under 1 Year Social Security Number Age (In yrs. last birthday) Funeral MCountry (IV) 1□ M 2☑ F Months Days Min. 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygiene. In Department of Health and Mertal Hygiene in Filem 7 is marked other than "natural" or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be multibled at 1 ☑Yes 2 ☐ No a Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ⅓ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Ś 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ntary/Secondary (0-12) College (1-4or 5+) atric Nursin Mother's Name (First, Middle, Maiden Surname 17. Fathers Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Name/Relationship (Type. Print) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimar Hamis Fl 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of duing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 46ARS /Medical Due to (or as a consequence Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) □Yes 2 No To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5'M Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27, Manper of Death 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler

State Registrar 30. Name and address of pers

Year)

31. Date filed (Month, Day,

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Inez J. Curtis 10/em/02/2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** n/a 10R F HOSPIAI 8. Date of Birth (Month, Day, Year) 7/28/1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 217-26-4536 85 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f sho MD 1 ☐ Yes 2 No Baltimore Catonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number HR 442 719 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White è 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than 2 should be filed within and Mental Hygiene. Instructional Aid 12 County Government 0 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer MacLeod Edna Sauerwald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dalton B. Curtis, Jr./Son 365 Bristle Ridge, Cape Girardeau, MO 63701 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 11/23/2009 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sign hure of Funeral Service License 4107 Wilkens Ave., Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 1 TYes 9 Unknown 9 Unknow signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 No 1 ☐ Yes 2 Z No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral ( 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. To the Funeral Director: completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ò within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Month, Day, Year)

32. 1

e and andress of person who completed cause 1 eath (Item 23a) (Type, Print)

TMD 711 Marden Choice In Catonsville MD 21778
32. Registrar's Signature

Liver A. Jane

D 30989

November 20 2009

			For State Registrar	State of M	larylan	•	artment of H		and M		giene Reg. No	2000	3 37540
			Decedent's Name (First, Middle)	e, Last)						2. Date of Dea	ath		3. Time of Death
	Physicia Medic		Kathl	een T.		C1e	ckin			NUVEMI	BER	y Zo, Yea	Ø9 5:15Р м
<b>.</b>	Examin		4a. Facility Name (if not institution	, give street and number)			4b. City, Town, or				4c	. County of Dea	ath
-	<i>t</i>		Saint Jose		1 Cer	nter			Tows	on		Da	ltimore
	Funeral Director		5. Social Security Number 215-40-1294	6. Sex 7. Aç 1 ☐ M 2 🏋 F	ge (In yrs. Ia 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month Da Aug 16		9. B 27 I	irthplace (State or Foreign ountry) reland
	now at	_	Usual Residence of Decedent  10a, State 10b. County		10c City	y, Town or Lo	cation						10d. Inside City Limits
	arylar a-fst fied	Director			100. 01								1 Yes 2 X No
	or 28	Ę	Maryland Bal  10e. Street and Number	timore		Coci	ceysville 10f. Zip Code				10a. Cit	tizen of What C	
	with 1 s 23a ust b	Funeral	824 W. Padoni	a Road			210	30			J	USA	•
	leath items	표	11. Marital Status	12. Was Decedent Armed Forces?			Vas Decedent of His f Yes, specify Cubar	spanic Ori	igin? (Spec	ify Yes or No-		14. Race - Am	
36	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Mar 3 🏿 Widowed 4 ☐ Divorced	ried 1 Yes 2 X			☐ Yes 2 🛣 No			iodii, oto.j		Black, Whi Specify:	white
ŏ	hours natura ical E	ete	15. Decede	nt's Education		16a. Deced	lent's Usual Occupa	ation			16b K	(ind of Business	
Maryland 21215-0036	nin 72 ne. han "r e Med	Completed	Elementary/Seconday (0-12)	est grade completed)  College (1-4 or	5+)	Ìife. Di	kind of work done d O NOT use retired)	ŭ	t of workin	g	1	identia	1/Commercial
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ž	d 2 sh alth ar 27 is rrtrau		James Clerkin				elton Roa					21093	up code)
Je,	1 and of Healt item 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		D	ate		ocation - City o	r Town, State
<u><u>Ĕ</u></u>	Page ment c ant: If ury or		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		Du	laney '	natory`or other place Valley Me	moria	al Ga	4/09 rdens	Tim	onium,	Maryland
Baltimore,	permit. Page Department of Important: if any injury or once.		21. schatur of runer livervice l	LUKU	-	22 Le	Name and Addresemmon Fun W. Pado:	s of Facilit eral nia R	Home	of Dul	lane	y Valle MD 21	y Inc.
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	cate be executed physician and the burial-transit	EX	that initiated events resulting in death) Last	Due to (or as									
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387	rtifica ling pl		IF FEMALE:	00. 1/	,								
Box 687	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 🔲 Feta	Ideath 3	Ectopic pregnancy Other (specify)	у			33	23d. Date of do	elivery Day Year
W	he dea y the a	hysid	1 ☐ Yes 2 ♠ No 9 ☐ Unknown	9 Unknown	at time or u	eatii 5 L	Other (specify)						
P.O.	res that the death certific signed by the attending I d be detached for use as	y Pi	Part II. Other significant condition	ons contributing to death t	out not resu	ulting in the u	nderlying cause give	en in Part	I.	23e. Did to	obacco u	use contribute t	o the cause of death?
ds,	v requires been sig should b	ted I	-							1 🗆 '	Yes 2	<b>X</b> No 3 □ F	Probably 4 🗌 Unknown
COL	law rei nas be e 2 sho	Completed by Physician/M								24a. Was autop	OSV	24b. Were a	utopsy findings available completion of cause of
æ	: The icate I									perfo 1  Yes	rmed? 2 <b>X</b> No	death?	es 2 🗓 No
<u>ita</u>	sician certif rector	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			Other	r.	th (Check				
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uc	nding ath. r: Afte ie fun	icat	1 Natural 5 Pendir 2 Accident Investig		y, Year)	injury	work?	? Yes 2 🗌				,	
Division of Vital Records,	or Atte fter de irecto n by tt	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At hor c. (Specify)	me, farm, stre	et, factory, office		2	8f. Location (S City or Tow			ural Route Number,
۵	pital o		29a. Certifier 1 X Certifying	Physician: To the best of					(1)				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director.	Medical	(Check 2 L Medical E	xaminer: On the best of Nurse Practioner: To the	examination	and/or invest	igation, in my opinior	n, death oc	ccurred at t	he time, date a	nd place,	, and due to the	cause(s) and manner stated.
	Vitt To t		29b. Signature and title of certifier				29c. License	number			29d. Dat	te signed (Mon	
			16rds	mo.				Ø639	74			11/20/0	9
			30. Name and address of person	who completed cause of c	leath (Item	23a) (Type, P		gene origin	- fort & Florida	361 MA	E) \/3	AND O	1 2014
	Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	ure /	FR DRIV	<u> </u>	OWSC	IIV. ME	IKYL.	AND 21	1204
	Registra	ar	MUAR	4 6009 Ken	m	p. 14	bankel					_	

DHMH 17 Rev 7/2009

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		Northwest Hospital			Randalist			Baltimore Co	ounty
Funeral Director		5. Social Security Number 6. S	7. Age (	In yrs. last birthda	Months Da		Min.		eign
		214-04-2082 1 L Usual Residence of Decedent	M 221F	26	Yrs.		12/28	/1982   \	Country) MD
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yland <b>ı-f show</b>	į	MD N/A		Balt	imore				1 X Yes 2 No
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with t ms 23s	<u>ra</u>	3648 Valley Te:	12. Was Decedent Ev		. Was Decedent of I		(Specify Yes or No-		erican Indian, Black,
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MD 21215-0036 12 should be filed within 72 hours th and Mental Hygiene 27 is marked other than "natur: umatic event, the Me iteal Exami	Completed	11th Grade		D	isabled			N/A	
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3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Mailcal Examiner must be notified at once.		Candice M. Cla.  20a. Method of Disposition	iborne						
Baltimore, MD 21215 permit Pages I and 2 should be file. Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the		1 X Burial 2 Cremation 3		crematory of	sposition (Name of o or other place)		Date	20c. Location - City	
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Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the och line.	e death. Do not en	ter the mode of dyin	g, such as cardi	ac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
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, P.O. Box 68760, res that the death certificate be signed by the attending physici be detached for use as the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy				23d. Date of delive	ery
Box 68760, e death certificate b the attending physiced for use as the but	cian	past 12 months?	1 Live birth 4 Pregnant at time	ne of 5	Fetal death 3 Other (Specify)	Ectopic pre	egnancy	Month	Day Year
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Division of Vital Records, P.O. is after deading Physician: The law requires that it safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaa	Completed	·					24a. Was a	n 24b. Were a	autopsy findings available
Recol The law cate has bage 2 sh	dmo						autops	ned? death?	
al R	Bec	25. Was case referred to medical			26.Pla	ce of Death (Che	1 Yes 2	W NO	Yes 2 No
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Divors affineral Divors affineral Divors affined in Filled in	Certification:	4 Homicide determined					or Town, Sta	ate)	
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vithin To the comple	Medical	29b. Signature and title of certifier	and manner stated.	- Indiana in		nse number	ed at the time, date a	29d. Date signed (M	
		Januah S. Shall	MA		0.0	.M.E.		November 19, 2	
	ŀ	30. Name and address of person who	· ·						
		Pamela E. Southall, MD	Assistant Medica		111 Penn Stre	et, Baltimore	e, MD 21201		
St Regist		31. Date filed (Month, Day, Year)	32 Registrar's		Mad				
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DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State	Pleas	- •			nd / D	epar	tment of the ficate of L	Health	and M	•	giene	•	0 0 9	) 2	751
	-	Registrar  1. Decedent's Name (F	irst, Middle,	Last)				Jerui	ilcate of L	Jeani		2. Date of D	Reg. No	o. <u>C</u>	00		of Death
Physicia		MARY	, -,	ŕ	C.	ATALA	NELLO	)				Month NOVEME	D	2 <sup>y</sup> 3 2	Year 2009		O A M
Medic Examin		4a. Facility Name (if no		_			ATION		b. City, Town, or		n of Death	110 / 1411	40	County	of Death	1	0 11
Funeral Director		5. Social Security Number	1	6. Sex 1 ☐ M		Age (In yrs.	last birtho	N.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi 03-02-	irth 1914		9. Birthi Coun	olace (State try) NY	or Foreign
Maryland 28a-f show otified at	Funeral Director	Usual Residence of De 10a. State 10 MD	b. County	ford			ity, Town o		ion						1	0d. Inside	City Limits
with the 23a or 1st be n	eral D	10e. Street and Number 1705 Ruge:		re					10f. Zip Code 2101	1.5			10g. C		Vhat Cour	ntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1  Never Married  3  Widowed 4		ed 1	Vas Decede Irmed Force Yes 2 Yes, Give ear or Date		J.S.	If Ye	s Decedent of Hes, specify Cuba	an, Mexic	an, Puerto	cify Yes or No Rican, etc.)	)-  -		k, White,		
within 72 hou giene. er than "natu e, the Medica	Completed	(Specify Elementary/Second	5. Decedent only highes lay (0-12)	t grade co	on <i>mpleted)</i> ollege (1-4	or 5+)	-   (°	Give kind	t's Usual Occup d of work done o NOT use retired) CET	ation during mo	ost of worki	ng	1	Kind of Bu	usiness Ind	dustry	
d be filed Mental Hy arked oth atic event	To Be	17. Father's Name (Firs Charles Ba		•								e (First, Middle Mallar		Surname	9)		
nd 2 shou'ealth and m 27 is m		19a. Informant's Name Richard B			ephew	)			Address (Street a Ruger Dr						tate, Zip (	Code)	
Page 1 ar ment of Hi ant: If iter ury or oth	/ 1	20a. Method of Dispos  1 X Burial 2  4 Donation 5	Cremation		oval from St	tate	cemetery,	cremat	on (Name of ory or other plac L Mem. Ga			Date 1-2009	1		City or To	wn, State MD	
permit. Departimport any inj		21. Signature of Funer	al Service Lic	ensee					lame and Addres								elAir
Physician/		23a. Part 1. Enter the shock, or heart fa Immediate Cause (Fin disease or condition	ailure. List or	complicationly one cau	se on each	used the dea				ig, such a	is cardiac c	r respiratory a	ırrest,			Approximation Interval Be Onset and	etween
Medical Examiner	Ĺ	resulting in death)  Sequentially list condi	tions	, _	Due to (or	as a conse	quence of)	e d	eminte	٧.							
uted d ansit	Examiner	if any, leading to imme cause. Enter Underlyin Cause (Disease or iinjuthat initiated events	ediate ng		Due to (or	as a conse	quence of)	:									
be egiciar buria	cal	resulting in death) Las	t	L	Due to (or	as a conse	quence of)	:									
tificat ng ph as th	Med	IF FEMALE:															
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pre in the past 12 mos 1 Yes 2 N 9 Unknown	nths?	1 4	Live Bir	me of pregr th 2  Fe nt at time o	tal death		ctopic pregnand other (specify)	су				23d. Dat Mor	te of delive	ery Day	Year
ires that the signed by Id be deta	þ	Part II. Other significa	nt condition	s contribu	ting to dea	th but not re	esulting in	the und	erlying cause giv	ven in Par	rt I.					ne cause of pably 4	death?
ne law requ e has beer age 2 shou	Completed											_ perl	opsy formed?	, c		osy findings	
an: Ti tifical tor, pi	Be C	25. Was case referred to	to medical				-		26. PI	ace of De	eath (Check	1 L Yes	2 30	10	Yes	∆L No	
nysici nis cel direc	To E	examiner? 1  Yes 2 N	10	Hospit	al: 1 🗌 Inj	patient 2	☐ ER/Outp	atient	3 DOA Oth	er: 4\\( \)	Nursing Ho	me 5 Res	idence	6 🗌 Othe	er (Specify	)	
ending Pheath. Pr. After the Prefuneral	Certificate:	2 Accident	Pending	ation	Ba. Date of (Month,	injury Day, Year)	28b. Tin injt		28c. Injury work M 1	yat <br Yes 2[	_	28d. Describe	how inju	ry occurre	ed		
tal or Atturs after de al Directo ed in by t		3 ☐ Suicide 6 4 ☐ Homicide	6 U Could n determin			Injury - At I , etc. <i>(Spe</i> ci		n, street	, factory, office			28f. Location City or To			er or Rural	Route Nun	nber,
the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 only one) 3	Medical Ex Certifying I	aminer: O	n the basis	of examinati	on and/or i	nvestiga	tured at the time ation, in my opinion th occurred at the	on, death e time, da	occurred at	the time, date	and place	e, and due	to the car	use(s) and m	nanner stated.
Vith vith Con		29b. Signature and title	of certifier	)					29c. License	e number	7				(Month, i	Day, Year)	× (
4		30. Name and address				`			t)								
Stat Registra		31. Date filed (Month, E	Day, Year)	19		Istrar's Sign		nd.	J)	<u> </u>	1014						
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

2009 37543

Anthony J. Carus	1	- For State	State	of Maryland /		tificate of	neaith and Me Death	intarriyg	Reg.		2009 375
Physicia	_	egistrar I. Decedent's Name (Fir	rst, Middle,Last)						Date of Death	ay Year	3. Time of Death
Medical Exami	ner	Anthony 3	J. Carus	30					Month D November 1		2315 hrs
		la. Facility Name (if not Upper Chesape				41	D. City, Town, or Location Bel Air			4c. County of E Harford	
Funeral Director		5. Social Security Numb		_	(In yrs. la	st birthday) Yrs.	if Under 1 Year If Un Months Days Hor		8. Date of Birth( 04-15-1	1	B. Birthplace (State or Foreign Country)  MD
		Jsual Residence of Dec	cedent								10d. Inside City Limits
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland propertient of Health and Mental Hygiene. Important: If time 72 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified</u> at once.	Ę	10a. State 10b.	.County Harford	_		Town or Location	on				1 Yes 2 X No
15 34 ne Maryland or 28a-f show i	Director	10e. Street and Number	r				10f. Zip Code		10g	. Citizen of What	Country?
the N	吉	1204 Blue	Bird Ct				21015			USA	Associate Deale
ath with items 23	uneral	11. Marital Status  1 X Never Married	2 Married	12. Was Decedent Armed Forces?	Everin U. X No	S. 13. Was	Decedent of Hispanic Ces, specify Cuban, Mexic	Origin? ( Spec can, Puerto R	cify Yes or No- ican, etc.)	White,	
ter de	린	3 Widowed	4 Divorced	1 Yes 2 If Yes, Give Year or Dates:	A NO		Yes 2 X No spec			Specify:	
ours af atural camin	d by	15. Decedent's Educa		ly highest grade com	pleted)	16a. Decedent	's Usual Occupation (Gi	ive kind of wo		6b. Kind of Busin	ness/Industry
36 nin 72 hc e. than "na dical Ex	Completed	Elementary/Seconda	12	College (1-4 or 8	5+)	None	35. 51 H. 57. H. 19			None	
d with	Son	17. Father's Name (Firs	st, Middle, Last)				18.Mot	ther's Name (	First, Middle, Ma	iden Surname)	
215 be file ntal H rked o	Be (	Louis N. 0					The	eresa l	M. Gross	(Mothe	State 7in Code
21 hould nd Me is ma ntic ev	ဥ	19a. Informant's Name/				1	Address (Street and I				
MC nd 2 si alth ar m 27		Louis N. (		(Father)	20b.		ottondale ( ition (Name of cemetery		Date Date	20c. Location - 0	City or Town, State
Ore, es la of He If ite				Removal from St	ate	crematory or oth	erplace) Frematory		24-2009	Baltim	ore MD
t. Pag rtment rtant: y or o		4 Donation 5 21. Signature of Funera	Other Specify:	ee —	ра	-	lame and Address of Fa	100			Home of BelAi
Bal permi Depa Impo injur	8	717	116			In	c 610 W. Ma	acPhai.	1 Rd Be	l Air, M	ID 21014
Physician		23a. Part I. Enter the d	isease, or comp	lications that caused	the death	. Do not enter t	ne mode of dying, such	as cardiac or	respiratory arre	st, shock, or hear	
'l le die al kaminer		Immediate Cause (Fina	al disease a.	Narcoti	_		Lon				Death
Adminis		or condition resulting in	n death)	Due to (or as a cons	equence o	of):					
	ē	Sequentially list condit if any, leading to imme	ediate	Due to (or as a cons	equence o	of):					
	Examiner	(Disease or injury that	initiated	Due to (or as a cons	equence (	of):					
uted d ansit	Exa	events resulting in dea	ath) Last d.	,							
50, the be executed sysician and burial - transit	Medical	X UNPENDED		AMENDED 2.3a	.27.2	28a-f.pe	rMe, g898	12/17/	09 TT _		
760, cate b physic	ĕ	IF FEMALE: 23b. Was decedent pre	ennant in the	23c. If yes, outco	me of pre	gnancy		ctopic pregna		23d. Date of of Month	delivery Day Year
certificanting	sician/N	past 12 months?		1 Live birth Pregnant a	t time of d	a atta	etal death 3Ed ther (Specify)	ctobic pregna			
Box death he atte	Physic	1 Yes 2 No		9 Olikilowii					loo. Bidto	haran was contri	bute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	b P	Part II. Other signific	ant conditions	contributing to dea	th but not	resulting in the	underlying cause given	in Part I.			Probably 4 V Unknown
ds, l equires een sig	Completed				-				24a. Was a		Vere autopsy findings available prior to completion of cause of
Division of Vital Records, tal or Attending Physician: The law require rs after death. After this certificate has been sifed in by the funeral director, page 2 should be in in by the funeral director, page 2 should be	ਵੁ									med? d	leath?  ✓ Yes 2 No
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/ital	e Be	examiner?		Hospital: 1 Inpat	ient 2	✓ ER/Outpatier	t 3 DOA Othe	er. 4 Nursin	g Home 5	Residence 6	Other:
of \oldsymbol{Of} \left\ ig Phy fier the neral of the present of t	=	27. Manner of Death	110	28a. Date of In (Month, Day	jury (Year)	28b. Time of			_	now injury occurr	ed
On tendin sath. or: A	i	1 Natural 2 Accident	5 Pending Investigat	11/19/	2009	unk	1Yes		unk		Dural Davida Niverbas Citi
VISI or Att fifer de Direct		3 Suicide	6 X Could not	28e. Place of	Injury - At		eet, factory, office building	ng, etc.	28f. Location (	Street and Numb State) Rind	er or Rural Route Number, Cit Ct. Bel Air,
Division of Vital   Hospital or Attending Physician: 44 hours after death. Funeral Director. After this certif	Certification:	4 Homicide	determine	(-F27		ome		and plane, and			
ne Hoe n 24 h ne Fur	Sa l	29a. Certifier 1 Connection one) 2 M	ertifying Physic ledical Examina	cian: To the best of exer; On the basis of ex	my knowle amination	edge, death occi and/or investig	urred at the time, date a ation, in my opinion, dea	ath occurred a	at the time, date	and place, and o	lue to the cause(s)
To the vithing To the	Medical	29b. Signa/ure and tit		and manner stated	d		29c. License nu				ned (Month, Day, Year)
	-	/ / n.	1.1	Och O			O.C.M.E	Ξ.		November	20, 2009
		30. Name and address	s of person who	completed cause of	f death (Ite	em 23a)					
PV		Laron Locke		stant Medical E	xamine	r 111 Per	n Street, Baltimor	re, MD 212	201		
	Stat	31. Date filed (Month,	Day, Year)	32. Fegist	rar's Signa	ature	a Nat				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONTEMBERY 22, Year 202 09:08M Harvey M. Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWSON Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Director 214-52-1862 60 Dec. 13. Marvland 1948 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore Parkville 1 🗌 Yes 2 😾 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9233 Harford View Drive 21234 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ¥ Yes 2 ☐ No If Yes, Give "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Housing Commission of and Mental Hygiene. Director Of Information Director College (1-4 or 5+) Elementary/Seconday (0-12) Anne Arnundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nial Franklin Cook Anna Mae Cook or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10310 Greenwood Street, Pox 169 Ellerslie, Maryland Pamela Pressman-sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel and Cremation Belair 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Nov. 24, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville Marvland 21234 Vondra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): CARDIOGENIC attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi HOURS that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063974 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMRAN SIDITOI.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

7601

32. Registrar's Signature

M. D.

OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 9:49 PM 2009 eor November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5. Social Security Number of Baltimore 9. Birthplace (State or Foreign Country) 38 Baltmore, MD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 218-38-4594 Usual Residence of Decedent Months Days Hours Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Marylan 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director mmore death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 21 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Ş permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural";, any lijury or other traumatic event, the Medical Exagone. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) univesisit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PATIENT KNOWN AS! ပ 19b. Mailing Address (Street and Number or Ru, I Route N mber, City or Town, State, Zip Code) Informa Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐ Removal from State 23/09 21. Signature/of Funeral Service Licenses man Rd Monkton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 D Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 18, 2009 D59062 M.O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 had J. Hansen, M.D. W

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Auna

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death November 19, 2009 **Physician** 3:30 A. M Chiampi Martha Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 607 Hickory Overlook Drive Harford Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Feb. 11, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** , 1927 West Virginia Days Min. 1 □ M 2 🕅 F 82 Director 202-20-6758 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Experiment must be purified at 1 ☐ Yes 2√No Directo Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 607 Hickory Overlook Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2XXNo Baltimore, Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 ∐ Yes 2√CXNo Specify. Specify: White 3 Vidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Montgomery Ward McCormick Havel Irene Hafer ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Burden / Daughter | 607 Hickory Overllok Drive Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 23, Evans Funeral Chapel 1 Burial 12 remation 3 Removal from State 5 ☐ Other (Specify) 4 Donate Forest Hill, MD 2009 Bel Air 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of).4 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş d 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \) Nursing Home \( \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 🗙 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) spital or Attending P nours after death. neral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D376/2

State

DHMH 17 Rev 1/2001

Registrar

5430 Campbell Blud White Morsh MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

H

M. ALABRAS

31. Date filed (Month, Day, Year)

			For State	State of Ma	aryland / Dep			vlental Hygi	ene	
			Registrar  1. Decedent's Name (First, Middle, Last	<i>t</i> )	Ce	rtificate of E	eath	2. Date of Death	eg. No. 2 1 1 9	37547
	Physicia		Dennis	,	Cotter			Month NOvember	Day Year	3. Time of Death  1:38 A M
	Medic Examin		4a. Facility Name (if not institution, give	street and number)	000001		Location of Death	INOVARIBLE	4c. County of Death	
1	2		2807 Page Drive				undalk		Baltimo	re
	Funeral Director		5. Social Security Number 6. Se 219–76–4715	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8, Date of Birth (Month, Day,	Year) Cou	hplace (State or Foreign intry)
			Usual Residence of Decedent		49 Yrs.			August 2	26,1960 Ma	ryland
	yland f sho	tor	10a. State 10b. County	imore	10c. City, Town or Lo	ocation Dunda	11-			10d. Inside City Limits
	e Mar r 28a- notifi	Direc	Md. Balt	THOLE		10f. Zip Code	TK		0g. Citizen of What Co	1 Yes 2 No
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	2807 Page Drive			Toi. Zip code	21222	''	USA	untry r
	death ritem iner m		11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14, Race - Amer Black, White	
036	s after ral", or Exami	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔽 I If Yes, Give Year or Dates.	No	1 ☐ Yes 2📈 No	Specify:		Specify: Wh:	
2-0	2 hour "natur	plete	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation	sina I	16b. Kind of Business I	ndustry
121	thin 7%	No.	Elementary/Seconday (0-12)	College (1-4 or 5-	lifo I	NOT use retired) Bricklaye			Construct	tion
9	led wi Hygid other ent, t	Be	8 years 17. Father's Name (First, Middle, Last)			DITCKIU		ne (First, Middle, M		01011
/lan	d be f Menta arked atic ev	입	David Leroy C	otter Sr.			Bet	ty Weima	n	
Baltimore, Maryland 21215-0036	2 shoul Ith and 27 is m		19a. Informant's Name/Relationship (Ty) Theresa Cotter	pe, Print) Wife		ing Address (Street a			City or Town, State, Zip	Code)
ē,	1 and of Healt item 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of			20c. Location - City or	Town, State
<u>E</u>	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory or other place Crematory		I .	Baltimore	, Maryland
Balt	permit. Page Department of Important: It any injury or once.	Į.	21. gna ure of Fune al Service Licens	** Conn	elly 2	2. Name and Addres Connelly	s of Facility	2007.00	Dundalk, P Dundalk, M	<sup>A</sup> • 21222
			23a. Part 1. Enter the disease or comp shock, or heart failure. List only or	olications that caused ne cause on each line	the death. Donot en	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician/	g y	Immediate Cause (Final disease or condition	a. Lun	& Conce	7				Onset and Death
_	Medical Examiner		resulting in death)	Due to (or a sa	onsequence of):					
1	d sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of).					
X	executed an and rial-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
00	e be e ysiciar re buri	dical		d						
6876	tificat ng ph as th	Mec	IF FEMALE:							
Box 6	death certificate be ne attending physicia ed for use as the buo	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	ivery Day Year
о. В	the de by the tached	hys	9 🗌 Unknown	9 Unknown			-			
ls, P.	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by	Part II. Other significant conditions co				en in Part I.	23e. Did tob	acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
COL	law rec nas bee 2 sho	nplet						24a. Was an autopsy	y prior to c	copsy findings available completion of cause of
Re	i: The icate l		05 Man and a state and disc.					perform 1 Yes 2	ned? death? No 1 ☐ Yes	2 🗆 No
<u>Ital</u>	siciar certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆 ER/Outpatie	_ Othe	ace of Death (Chec	-1	nce 6 🗌 Other (Speci	***
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s		27. Manner of Death  1. Natural 5 □ Pending	28a. Date of injur (Month, Day,	y 28b. Time o	f 28c. Injury work	at	28d. Describe hov		19)
Visio	r Attencter death	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ry - At home, farm, st . (Specify)		res 2 🗀 No	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
۵	ospital o	Medical C							e(s) and manner as sta	
ĺ	the Ho thin 24 the Fu mplete	Med	(Check 2 Medical Examination of Certifier 29b. Signature and title of certifier	ner: On the basis of ex Practioner: To the !	camination and/or inve	death occurred at the	time, date and pla	ne, and disctother	tause(s) and manner as	
	<b>6</b> 00		Den Cles	lufuld	m	29c. License	4356		ed. Date signed (Month	9
			30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type,	Print) DZ FORAL	Win Sa	Dr. Ru	Atimore in	ND 21237
i	Stat Registra		31. Date filed (Month, Day, Year)  NOV 2 4 2009	32. Registra	r's Signature	A	11100		- V	
_				1	100					

09-08979		Please Type	or Print in Ri	ack Indelih	ole Ink. Ei	nsure A	II Copies /	Are Leaib	le.	
Maria Domingos- A	1	ujo State	e of Maryland	/ Departme	nt of Healt te of Deati	th and M	lental Hygi	ene Reg. N	21	009 3754
Physician	7	egistrar I. Decedent's Name (First, Middle,La	ist)				2. [	oate of Death Nonth Da Ovember 19		3. Time of Death 0951 hrs
Medical Examine		Maria Domings - I	Yauro ive street and number	)	4b. City, T	own, or Local			4c. County of De	
		Franklin Square Hospital			Rose		11 To 0411 To	Data of Right		Birthplace (State or Foreign
Funeral Director			Sex 7. Ag	ge (In yrs. last birth	Month		dours Min	10-25-		Country)
à		Usual Residence of Decedent		10c. City, Town o	r Location	21				10d. Inside City Limits
d d d		MD 10a. State 10b. County		Baltim						1 X Yes 2 No
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other tranumer event, the Medical Examiner must be notified at once.	2	10e. Street and Number 6172 Radeke	Avenue		10f. Zip	Code 2120	6	10g.	Citizen of What C	ountry?
ems 23st t be not	- L	11. Marital Status  1 X Never Married 2 Marrie	12. Was Deceden		13. Was Decede	ent of Hispanio fy Cuban, Mex	c Origin? (Specif xican, Puerto Ric	y Yes or No- an, etc.)	14. Race - An White, etc	nerican Indian, Black, c.
ter deat	<u>-</u>		1 Yes 2 ed If Yes, Give Year	X No	1 Yes 2	X No sp	ecify:		Specify:	Black
natural	9	15. Decedent's Education (Specify	only highest grade co	mpleted) 16a. D	ecedent's Usual uring most of wo	Occupation (	Give kind of work NOT use retired)	done 16	b. Kind of Busine	ss/Industry n/a
136 thin 72 l ne. than "y edical E	ompieted	Elementary/Secondary (0-12) a	College (1-4 or	5+n/a						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	וכ	17. Father's Name (First, Middle, La					other's Name (Fill Helena			
212 auld be a Mental marke		Abel D. Araujo 19a. Informant's Name/Relationship		19b	. Mailing Address		d Number or Rura	Route Numbe	r, City or Town, S	tate, Zip Code)
MD  1d 2 shc alth and m 27 is aumati		Helena D. Art	is - Moth		5172 Raf f Disposition (Nat				Oc. Location - City	
iore, ges l ar t of He : If ite		20a. Method of Disposition  1 X Burial 2 Cremation		cremato	ery or other place	)	l l			<del>Co,</del> MD
Baltimore, MD oemit. Pages I and 2 shc Department of Health and Important: If item 27 is important: And a	ŀ	4 Donation 5 Other Spec 21. Signature of Taneral Service Li		King M			acility Marc	n Eas		
	1	23a. Part I. Enter the disease, or co	And the same	d the death. Do no			North A			Approximate Interval
Physician Moi al caminer	1	failure. List only one cause on Immediate Cause (Final disease	each line. a. <b>Sudden u</b> i	nexplaine						Between Onset and Death
	1	or condition resulting in death)  Sequentially list conditions,	Due to (or as a cons	sequence of):						
	aminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of):						1
	×	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con:	sequence of):						
executed an and al - transit	ica	X UNPENDED	d. X AMENDED 23	a <b>,27,28a</b> - em#20b,c,	-f,permE	<u> </u>	1/22/10	TT		
68760, certificate be nding physic se as the buri	Physician/Medical E	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outco	ome of pregnancy			Ectopic pregnanc		23d. Date of del	livery Day Year
x 68 th certif	ician	past 12 months?	7 0	at time of death			ectopic pregnanc	, 	l Wionian	Suy
the death control the attention the attention ched for us	Phys	1 Yes 2 ✓ No 9 Unknot  Part II. Other significant condition	o oaro	ath but not resulting	g in the underlyin	g cause giver	n in Part I.	23e. Did toba	cco use contribut	te to the cause of death?
P.O.	۵							1 Yes	2 No 3	Probably 4 V Unknown
ords.	Completed							24a. Was an autopsy	prio	re autopsy findings available ir to completion of cause of
Recc The lar	E O							perform 1 Yes 2		Yes 2 No
of Vital Records, ag Physician: The law require ther this certificate has been si	å	25. Was case referred to medical examiner?	Hospital: 1 Inpat	tient 2 🗸 ER/O	utpatient 3	-	Death (Check on ner, Nursing I		esidence 6	Other:
of V ng Phy After th	일	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day	njury 28b.	Time of Injury	28c. Injury a		_	w injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	1 Natural 5 Pendin Investin 3 Suicide 6 X Could determ	pation 28e. Place of	19/09 Fd Injury - At home, fa house	8:58 am			Bf. Location (Str	eet and Number of te) 6172 Ra	or Rural Route Number, City
lospital 4 hours 2 uneral		29a. Certifier 1 Certifying Phy	sician: To the hest of	my knowledge de	ath occurred at the	ne time, date	and place, and di	ue to the cause	s) and manner as	s stated.
To the I within 2. To the F	Medical	one) 2 Medical Exam	ner:On the basis of ex and manner state	kamination and/or i	nvestigation, in r	ny opinion, de	eath occurred at t	he time, date ar	nd place, and due	to the cause(s)
. > - 0	žΙ	29b. Signature and title of certifier			2	9c. License n	umber		zed. Date signed	(Month, Day, Year)

111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month Day, 2009 32. Registrar's Signature

30. Name and addresse of person who completed cause of death (Item 23a)

November 20, 2009

8

State Registrar O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Franklin Doster, Sr. 22. 2009 November 5:50 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1002 Union Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 9, Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days **XX**M 2□ F 219-01-1362 88 Maryland Aug. 20, 1921 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Le Medical Examination of the state of the s 1X Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1002 Union Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify. Specify: White ð 3℃Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wh Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other traumatic event. Electrician Electrical Company 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Doster Frances Barbara Menikheim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Sarah Linda Doster (Daughter) 1002 Union Avenue, Baltimore, Maryland 21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial 11/25/2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 Jum HENSS 3631 Falls Road, Baltimore, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IN FAR CTION Physician MYUCARDIAL /Medical Due to (or as a consequence of): **Examiner** CARDIOVASCULAR TEARS DISPASE ARTERIUSCUERUTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 The law requires THROMBOCYTOPENIA 1 Probably 4 Unknown Completed HYPER TEWSIUN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation n 24 hours after death.

• Funeral Director: A

bletely filled in by the fi 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ) mall I Name and address of person who complet of cause of death (Item 23a) (Type, Print) 6535 N. Charles St.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #9 per FH G897 11/24/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE VIA MEDICAL CEATER ALTIMORE 8. Date of Birth (Month, Day, Year) 11/29/1943 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. U.S.A. MARYLAND Yrs. 219-38-5934 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits i show ir than "natural", or items 23a or 28a-f si the Medical Examiner must be notified Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 North Stricker Street U.S.A. Funeral 21217 12. Was Decedent Ever in U.S. Armed Forces? 1▲ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ğ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sparrow Print Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed we Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic acceptance. 12th Grade Retired Crane Operator Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Payne ဂ Cecil Dias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Washington(friend) 933 N. Stricker St., Baltimore, MD 21217 20a, Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/09 Garrison Forest Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LUNG MASS 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident To the nuspersor within 24 hours after death.

To the Funeral Director: After the funeral py the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person wh

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ST. BALLIMURE, MI. 21201

of death (Item 23a) (Type, Print)

Phys /Me Exan

Funer Directo

	/ /N	amine
	EX	amine
Division of Vital Records, P.O. Box 68760,	ital or Attending Physician: The law requires that the death certificate be executed	ans after treating the sertificate has been signed by the attending physician and rate Director; After this certificate has been signed by the attending physician and lifed in by the funeral director, page 2 should be detached for use as the buriat-transit

	1 - For State Registrar				Ce	rtificate of l	Death		Reg. I	~ZUU9	3/33
an	1. Decedent's Name (Final Anna M. D		-						Date of Death Month 1-19-20(	Day Year	3. Time of Death
er	4a. Facility Name (If no. 108 K Gwen	t institution, giv		er)		4b. City, Town, or Forest				lc. County of Death Harfo	
	5. Social Security Numb 216-12-237	3 1	ex 7. □ M 2	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, Yea -12-1920	r) Cou	nplace (State or Foreig untry) MD
	Usual Residence of Dec 10a. State 10	b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
CIOL	MD	Harfor	d	F	orest	Hill					1 ☐ Yes 2 📉 No
ral Director	10e. Street and Number 108 K Gwe		2			10f. Zip Code	050		10g.	Citizen of What Cou	untry?
by Funeral			12. Was Decede Armed Force 1 ∐Yes 2 If Yes, Give Year or Date	es? ⊠No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2ሺI No	ispanic Origii in, Mexican, I Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
Completed by	15. (Specify of Elementary/Secondar	Decedent's Econly highest gra	ducation ade completed) College (1-4	or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most o l)	of working		Kind of Business/I	ndustry
S	17. Father's Name (Firs	st Middle Last	1		пошеш	akei	18 Mother's	s Name (Fi	rst, Middle, Maid		
To Be									Fulco		
Ė	19a. Informant's Name		Type. Print)		19b. Mailir	ng Address (Street				y or Town, State, Z	ip Code)
	Joan T. Zit	o (Cou	ısin)			K Cliffo		ne For			
	20a. Method of Disposit 1 X Burial 2 ☐ C 4 ☐ Donation 5 ☐	remation 3		ite		sition (Name of matory or other plac Valley		Date -23-2		Location - City or I	
	21. Signature of Funera	al Service Licer	isee								ne of BelAi
	23a. Part 1. Enter the d	X				nc. 610 W				Air, MD 2	21014 Approximate Interval Between
Medical Examiner	Immediate Cause (Fina disease or condition resulting in death)  Sequentially list condition if any, leading to immediate, enter Underlyin Cause (Disease or injuithat initiated events resulting in death) Last	ons, diate ng ry	bDue to (or	as a consequal as a c	ence of):	_ Per v	h.E c	)FF1C	E Csm	) (C +171v	Onset and Death
ruysician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ No 9 □ Unknown	nths?	23c. If yes, outco 1  Live birl 4  Pregnal 9  Unknow	th 2□Fetal ntattime of d	death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			23d. Date of deli Month	very Day Year
id by r	Part II. Other significar	nt conditions o	ontributing to deat	h but not resu	Iting in the u	nderlying cause give	en in Part I.				the cause of death?
Completed by								_	24a. Was an autopsy performed 1 □ Yes 2 🔀	prior to o	topsy findings available completion of cause of 2  □No
Re	25. Was case referred texaminer?	to medical					26. Place o	of Death (C	1 ∐Yes 2 🕦 heck only one)	10163	2 010
	1250 Pes 2 □ No		Hospital: 1 ☐ Inp			nt 3 DOA Oth	4 🗆 Nuis			6 ☐ Other (Spec	cify)
Certification: 10	2 Accident	☐ Pending investigation			28b. Time o	M 1 □	yat ⟨? Yes 2 □ No	0	Describe how in		und Deute Mumb av
Certi	4 Homicide	determined	building	, etc. (Specif)	′)	eet, factory, office			City or Town, St		
Medical	(Check only 2 one)	Medical/Exar	nysician: To the be niner: On the bas and manne	is of examinat	wiedge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and occurred	at the time, date	and place, and due	to the cause(s)
Σ	29b. Signature and title	of certifier		*·		29c. Licens	e number	843	29d.	Date signed (Month	n, Day, Year) W W
9	30. Name and address 31. Date filed (Month, E	Heccin	1 20	of death (Item	vill.	Print) SPRILCE	Rd	Fe	FRUIT H	rll mi	w 20,200 2050
r	MUAS	2 6447	100m	B.	gran.	3					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 11 2009 8:20 A Marilyn C. Donnelly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5521 Weywood Drive Reisterstown, MD Baltimore 5. Social Security Number (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year) 2-22-1928 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Months Hours 81 212-24-7509 Baltimore, Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f shout the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5521 Weywood Drive 21136 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Pages 1 and 2 should be f nent of Health and Mental ant: If item 27 is marked o Roy Wheeler ပ Charlotte Michael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Donnelly -daughter 7934 Bright Meadow Ct. Ellicott City, MD 21043 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 11-21-2009 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, INC. 21. Signal re Furieral Service Licenses 1328 Sulphur Spring Road Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia zheimer's **Physician** Years /Medical Examiner Sequentially list conditions, if any later Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 2 No 3 Probably 4 Unknown 1 Yes Completed been 24a. Was an Were autopsy findings available prior to completion of cause of funeral director, page 2: autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

law requires that the death certificate be executed Division of Vital Records, has or Attending Physician: The certificate this After death. after death within 24 hours a the Hospital

filed within 72 hours after death with the Maryland

Hygiene.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Douglas Pinto 3421 Benson Avenue Suite 3 Baltimore MD 21227 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2,23a per doc 888 12-1-09 yt. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	ertificate of	Death		Reg. No. 2	nna	37553
	Physic	an	1. Decedent's Name (First, Middle, La	· ·				2. Date of De Month	ath <b>20</b>	Year	3. Time of Death
	/Medi		Elizabeth Ann					Nov.	<del>11</del> ,	2009	10:20AM
	Examir	ner	4a. Facility Name (If not institution, given Ivy Hall Nursi	· ·		4b. City, Town, o	r Location of Death			ity of Death . timo:	r 0
	Funeral	_	Social Security Number 6. 8	Sex 7. Age (In )	yrs. last birthday	If Under 1 Year		8. Date of Bir			ace (State or Foreign
	Director		219-26-7081	1□M 2 <b>∏</b> F	69 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Feb. 29	y, Year) 1940	Mary	rland
	pu »		Usual Residence of Decedent  10a, State 10b, County	10-	Oit. To and						Od bedde O'r Deelle
	larylan show	5	10a. State 10b. County  Maryland Baltimo		City, Town or L arkville					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	rect	10e. Street and Number	1.		10f. Zip Code			10g. Citizen o	f What Coun	
	3a or	Ö	8313 Nunley Dr. A	pt. E		21234			U.S.A.		,.
	deatl	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	- 14. Ra	ace - Americ	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madral Eval in the motified at	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ऋ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No		Rican, etc.)		ack, White, e	
5-(	72 h	lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	edent's Usual Occup kind of work done	during most of work	ing	16b. Kind of	Business/Ind	dustry
121	within ene. <b>than</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired sterd Nurs	,		Health	. Care	
<b>d</b> 2	filed Hygi other ent,	BeC	17. Father's Name (First, Middle, Last	<u>-</u>		Joseph Mari	18. Mother's Nam	e (First, Middle,			
lan	lld be fental rked tic ev	To B	Albert Milton Fi	sher			Doris Ko	hlbauer			
ary	12 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, 1 to M.	_	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ing Address (Street	and Number or Rui	al Route Numb	er, City or Tow	n, State, Zip	Code)
₹,	alth alth		Mrs. Beth Hardy (Daugh			ng Charles	Cir. Baltim	ore, Mary			
Baltimore, Maryland	Pages 1 nent of H ant; If iter ary or otl		20a. Method of Disposition  1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specit	Removal from State   E	b. Place of Disp Vans Fune Bel A	osition (Name of matory or other place in	Novemb 20		20c. Location	•	wn, State Maryland
Balt	permit. Pages 1 a Department of He Important: If item any Injury or othe		21. Signature of Funeral Service Licer	Sellen AD	E	ans Funder 300 Harford			Service	s - Par	
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5	Physician		Immediate Cause (Final disease or condition	^	tage	Liver	lisease				Onset and Death
z	/Medical Examiner		resulting in death)	Due to (or as a cons	sequeme of):						
	Zxammer	늘	Sequentially list conditions,	b. Due to (or as a cons	ohol	ism					
	utec d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 to (01 as a cont	sequence on.						
δ. 0	an andrial-tra		that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
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39 )	ertifica ling ph e as th	Med	IF FEMALE:			-					
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre  1  Live birth 2 F  4 Pregnant at time 9 Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			ate of delive Month	ery Day Year
٣.	that the ed by detacl		Part II. Other significant conditions of	contributing to death but not	resulting in the u	ınderivina cause aiv	en in Part I.	23e. Did to	obacco use co	ntribute to th	ne cause of death?
Division of Vital Records,	law requires that the dias been signed by the 2 should be detached	Completed by	Anemia		<u> </u>				∕es 2∐No		ably 4 🗆 Unknown
Sec	e faw r has be e 2 sh	nple						24a. Was	osy	prior to con	psy findings available inpletion of cause of
<u>a</u>	n: The ficate h r, page							perfo 1 □ Yes	rmed? 2 A No	death? 1 ☐ Yes	2 □ No
Ħ	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Deat				
o	g Phy er this eral di	2	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injur	y at	me 5 Residente la			y)
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ivis	To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ec <i>ify)</i>	reet, factory, office		28f. Location (S City or Tov		nber or Rura	l Route Number,
	Hospital 24 hours a Funeral C		29a. Certifier 1 Certifying Ph	nysician: To the best of my	knowledge deal	th occurred at the ti	me date and place	and due to the	cause/s) and i	manner as s	tated
	n 24 h	Medical	(Check only 2 Medical Exar	niner: On the basis of exam and manner stated.	nination and/or in	nvestigation, in my c	ppinion, death occur	red at the time,	date and place	, and due to	the cause(s)
	To the within 2 To the comple	ĭ	29b. Signature and title of certifier	/	2	29c. Licens	e number		29d. Date sign	ed (Month, I	Day, Year)
			Calle	un xl	Sell	MD DO	062194		11/	2110	29
	3		30. Name and address of person who	completed cause of death (	tem 23a) (Type,	Print)					
	Sto		30 St. Paul 31. Date filed (Month, Day, Year)	32. Registrar's Signature	# 519	1 130	Itimore	m	0 31	202	
	Sta Registr		NOV 2 4 2009	Diverse B	· March	A STATE OF THE STA					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** T9,2009 Martina November Decker 6:55 A M /Medical 4a. Facility Name (If not institution, give street and number) Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 7 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Funeral Year. Days 1 □ M 2 🕅 F Hours 216-12-5037 86 .1923 **Director** Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at 1 ☐ Yes 2√☐ No Director MD Anne Arundel Millersville 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 8343 Watermill Drive 21108 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examitment Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other trailmests. 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theordore J. Wilson Mary Edna Saffield 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Nancy Ruskey/Daughter 8343 Watermill Drive Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Vets. Cem. 23, 2009 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee MO1580 lattito Services PA 1 2nd SW Ave. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Immediate Cause (Final disease or condition resulting in death) Physician 48414 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. the detached 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an has page 2 autopsy performed? Yes 2 No The certificate 1 □Yes To the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Dursing Home 5 Pesidence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) Gor 101 a 14 31. Date filed (Month, Day, Year Registrar's Signature State Registrar

ÖRIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death NOVEMBER 20, 2009 **Physician** 5:55 A M DIVINSKY MIKHAIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE SINAI HOSPITAL 8. Date of Birth Month Day Year 7 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** Days Hours Min. 1**X** M 2 □ F Months UKRAINE Director 214-15-4877 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 1 X Yes 2 □ No Director BALTIMORE N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with USA 3601 FORDS LANE, #601 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? 1 Tyes 2 X No 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 □ Never Married 2 □ Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify ģ Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 'natural", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) 4 PETROLEUM <u>ACCOUNTANT</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DIVINSKY **GERSH** BRYNA BRUSILOVSKY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7202 ROCKLAND HILLS DRIVE, #207, BALTIMORE, MD 21209 TATYANA LOZOVATSKY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 11-22-2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Sign ture of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUULAN Sequentially list conditions Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 1 🗆 Yes After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

### Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Mogth, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) DUT (T) MI ul Day, Year) 32. Registrar's Signature 31. Date filed (Month) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** November 2009 5:00 P M Nelson W. Eisel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2703 Goodwood Road Baltimore City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Days Months 1 M 2 □ F 89 213-14-8959 Aug. 25, 1920 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2703 Goodwood Road 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married or, WII Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White ģ 3

Widowed 4 □ Divorced natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, I'm Med 2008. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Firemen 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Eisel Nellie Lew P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4108 Westmeath Road, Nottingham, MD 21236 Madeline Wedemeyer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 11/23/09 1 N Burial 2 □ Cremation 3 □ Removal from State Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation 8800 Harford Road, Parkville, M

23a. Part1. Enten he trisease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Immediate Cause (in male disease or condition) 8800 Harford Road, Parkville, MD 21234 Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the buriat-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Ye ar in the past 12 months? Month 5 Other (specify) P.O. 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 300 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 🚧 a. Was an performed 2 🗆 No 1 □Yes 2 121No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not b 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6 40. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -6 31. Date filed (Month, Day, egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dece 2. Date of Death nt's Name (First, Middle, Last) Physician/ Medical (if not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. las birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Month, Day, Director Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ö Š 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event: the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ mant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State 3 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - Oty or Town, State NOVEMBER Date ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) Instu Signature of Funeral Service Licensee 22. Name and Addre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last this certificate has been signed by the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No I ☐ Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

DAVID EVANS

Hospital or Attending Physician: The law requires that the death certificate be the funeral director, page 2 should be detached

24 hours after death.

Funeral Director: After completed filled in by within 2 To the F

Medical

29a. Certifier

(Check

only one) 29b. Signature and

State Registrar

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

determined

JONES,

Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

City or Town, State)

TIMONIUM, MD 21093

29d, Date signed (Month, Day, Year)

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			For State	State of Man		epartment of I Ce <i>rtificate of I</i>		/lental Hygi	ene	
			Registrar  1. Decedent's Name (First, Middle, Last	)		sertificate of t	Jean	2. Date of Death		3. Time of Death
	Physicia Medio			ord				Month November	20, 2009 Year	8:20a M
	Examin	er	4a. Facility Name (if not institution, give s 9106 Abigail Drive			4b. City, Town, o Rosedal	r Location of Death		4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign try)
	faryland Ba-f show tified at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	)	oc. City, Town o Rosedal					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the N s 23a or 20 nust be not	Funeral Director	10e. Street and Number 9106 Abigail Drive	e, Apt. 4D		10f. Zip Code 21237			og. Citizen of What Countited State	,
9036	e filed within 72 hours after death with the Maryland Ital Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 hor giene. ner than "nat t, the Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	ucation de completed) College (1-4 or 5+)	(C)	ecedent's Usual Occup Give kind of work done de. DO NOT use retired) Chiatric N	during most of work	<sup>ing</sup> S	6b. Kind of Business In pring Grove ospital	
yland ;	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Harrison Pratt				18. Mother's Name Minnie	e (First, Middle, Ma Asbury	aiden Surname)	
e, Mar	permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever once.		19a. Informant's Name/Relationship (Type Dianna Shaneyfelt	/ Daughter	910	6 Abigail	Drive, Ap	t. 4D, B	altimore,	Maryland 21237
timore	ft. Page 1 a rtment of F rtant: If ite njury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery,	isposition (Name of crematory or other place rematory)		nber 21. 09 B	altimore, M	•
Ba	Depa Impo any is	g d	21. Signature of Funeral Service License		e Iser	Cremation 299 Freder	Society c ick Road	f Maryla Baltimo	nd, Inc. re, Marylan	nd 21228
	Physician/ Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. a.	1		g, such as cardiac o			Approximate Interval Between Onset and Death
	Examiner	Ļ.	Sequentially list conditions,	Due to (or as a co	nsequence of):				-	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or illinjury that initiated events	Due to (or as a co	nsequence of):					
09/	cate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a co	nsequence of):					
. Box 687		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3	sy		23d. Date of deliv Month	ery Day Year
ds, P.O.	quires that the signed by all be detact	by	Part II. Other significant conditions con Diabete	ntributing to death but n		he underlying cause gi	ven in Part I.		acco use contribute to the	
Records,	The law rec cate has bee page 2 sho	Completed	Hypen	fensi'o	4			24a. Was an autopsy perform	prior to co death?	psy findings available mpletion of cause of
or Vital	sician: certific	To Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	lospital:	2 ☐ EB/Oute	26. Pl	ace of Death (Checker:	1		
on of \	arth. arth. r: After this	Certificate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye	28b. Tim	e of 28c. Injury	y at	me 5 tyr Hesiden 28d. Describe how	ce 6 Other (Specify injury occurred	)
DIVISION	tal or Atterns after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)		, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	the Hospi thin 24 hou the Funer mpleted fill	Medical	(Check 2   Medical Examin only one) 3   Certifying Nurse	cian: To the best of my er: On the basis of exami Practioner: To the best	ination and/or ir	vestigation, in my opinio ge, death occurred at th	on, death occurred at e time, date and plac	the time, date and e, and due to the c	place, and due to the ca ause(s) and manner as st	use(s) and manner stated, ated.
D	D Will		29b. Signature and title of certifier	D- 0,	0,	29c, License	3559°	3	d. Date signed (Month,	pay, Year)
			30. Name and address of person who of	empleted cause of death		ne, Print)  Mare H	U.e., B	altin	rore Me	2/22/
H	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's S		An all li				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 DONALD  $\mathbf{E}$ FLEMING 12:05 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** 1 ፟፟፟፟ M 2 □ F Days Hours Director 88 214-16-0548 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ha movitand and injury or other traumatic event, the Medical Examinar must ha movitand and injury or other traumatic event, the Medical Examinar must ha movitand and injury or other traumatic event, the Medical Examinar must have movinated and injury or other traumatic event. 10a. State 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1709 S. Main St. 21771 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 If Yes, Give Year or Dates. 1942-46 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery Co. Schools 8 HVAC Mechanic Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward W. Fleming Nettie Virginia Haugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 S. Main St., Mt. Airy, MD 21771 Tom Fleming/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/25/09 Pine Grove Cemetery Mt. Airy, MD 21. Signature of Funeral Service Licen Burrier Advice Ficili Funeral Home & Crematory, P.A. Maket ork 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Unpengensive CAMBIOURSCHUMN DISABE disease or condition warno Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month 5 Other (specify) signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. 1 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a ledical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Murse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital

State Registrar

only one) 29b. Signature and title of cer

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Miller,

.0. P

Registrar's Signat

Box 210, Mt. Airy, MD 21771

026499

29d. Date signed (Month, Day, Year)

11-22-09

			1- For Amend Item 26 State of Maryland / De Registrar	partment of Health and M 1724/09dhb.31 ertificate of Death	lental Hygier Reg. I	ne 2009 3 <b>75</b> 60
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Melvin Hubert Finney		2. Date of Death	13, 2009 3. Time of Death 0210 M
	Exami		4a. Facility Name (If not institution, give street and number) Gift of Hope Hospice	4b. City, Town, or Location of Death  Baltimore		4c. County of Death
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212–60–6697 1 № 2   F 57 Yrs.		8. Date of Birth (Month, Day, Yea 02/26/195	Maryland  9. Birthplace (State or Foreign Country)  5.2 Maryland
	ryland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	the Ma	Director	Maryland N/A Baltimor	10f. Zip Code	10-	1 ☐X es 2 ☐ No Citizen of What Country?
	ath with 23a or ust be	raDi	818 N. Collington Avenue	21205		nited States
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto     □Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc.  Specify: Black
21215-0036	vithin 72 ho ane. :han "natu e Medicel	Completed	(Specify only highest grade completed) (Gin Elementary/Secondary (0-12) College (1-4or 5+)	redent's Usual Occupation we kind of work done during most of working DO NOT use retired)	ng	Kind of Business/Industry
nd 2	e filed v al Hygie I <b>other i</b> vent, II	Be Co	17. Father's Name (First, Middle, Last)	Se Keeper  18. Mother's Name	(First, Middle, Maide	en Surname)
Maryland	should b nd Ment marked matic e	To	Unknown Finney  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	Eugenia V		
e, Ma	and 2 stealth arm 27 is her trau		Sr. Vineeth - Caretaker 818	ling Address (Street and Number or Rura N. Collington Avenu	ie Baltimo	ore, Maryland 21205
altimore,	Pages 1 nent of H nt: If ite		A Daniel E Dictination o Differnoval nont State	ematory or other place)	,	Location - City or Town, State
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lieunsee	22. Name and Address of Facility David J. Weber Fune	ral Homes	altimore, Maryland
			23a. Part 1. Enter the disease of orications that caused the death. Do not e shock, or heart failure. St only the cause on each line.	401 S. Chester Stre	<u>et Baltım</u>	ore, Maryland 21231  Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	Rectal Cancer	to liver a	Onset and Death
	Examiner	e.	Sequentially list conditions			
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.			
68760,	ficate be executed physician and s the burial-transit	edical E	Due to (or as a consequence of):  d.			
	or to repart or <b>Attending Physician</b> : Into law requires that the death certification to the relations after the certification to the <b>Funeral Director</b> . After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in the funeral director.	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
, P.O.	that the ned by the detach	y Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords	requires	sted by	HIV/ AIDS		1 ☐ Yes 2	2 No 3 Probably 4 Unknown
Division of Vital Records,	n: The law ficate has t r, page 2 s	Completed	ESOPHAGEAL STRICNRE		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  Io 1 □ Yes 2 □ No
ž Š	ding Physician: The h. After this certificate h. funeral director, page	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	26. Place of Death ent 3 DOA Other: 4 Nursing Hom	(Check only one)  ie 5 ☐ Residence	6 Nother (Specify) Hospice
on !	ath. r: After i	ation:	27. Manner of Death  1 Addural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury		Bd. Describe how inju	
Divis	al or Arre s after de al Directo	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	Bf. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
	ne nospir in 24 hour he Funera pletely fille	Medical	29a. Certifier (Check only one)  12 ertifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause( d at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s)
	To the confliction	Σ	29b. Signature and title of certifier  BM 6Ch	29c. License number		ate signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
	Stat	е	31. Date filed (Month, Day, Year)  NOV 2 4 2009  32. Registrar's Signature  A	nikel		
	Registra	r	NUV Z 4 LOUS LAWE P. LA	Chen		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2000

			For State Registrar		State of M	arylan	-		nt of He te of De		Mental Hy	_	0.0.0	0 07561
	Physicia	m/	Decedent's Name (Fig. 1)	irst, Middle, Las	t)			- Tour	0 0, 0	<u> </u>	2. Date of De	Reg. N	200	3. Time of Death
	Physicia Medi	cal		ginia			Fuller				Novem	<u>œr</u>	22, 200	
wit	Examir	ner	4a. Facility Name (if not Gilchri		iter			4b. City		ocation of Death		40	c. County of Dea	imore
	Funeral Director		5. Social Security Numb 233-38-509 Usual Residence of Dec	90 6. Se		e (In yrs. Ia	ast birthday) 1 Yrs.	If Unde Months	er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	th y, Year)	a Rie	thplace (State or Foreign suntry) est Virginia
	and show dat	ŗ	10a. State 10l	b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits
	Maryl 28a-f otifiec	irect	Md.		imore			Dur	ndalk					1 ☐ Yes 2 🙀 No
	h with the ns 23a or nust be n	Funeral Director	1702 Les		d					1222			itizen of What Co	-
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		<ul><li>11. Marital Status</li><li>1  Never Married</li><li>3  Widowed 4 </li></ul>		12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			_	dent of Hisp cify Cuban, 2 ☑ No		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
21215-0036	thin 72 hour me. than "natu ne Medical	Completed by	(Specify Elementary/Seconda		ucation de co <i>mpleted)</i> College (1-4 or 5	i+)	16a. Deced (Give k life. DC	ind of wo NOT us	ork done dur e retired)	ring most of won	king		Kind of Business	
d 2	led wil Hygie other ent, th	Be C	12 year 17. Father's Name (First,		1 year			Se	ecreta 1		ne (First, Middle,		Steel Inc	dustry
ylan	d be filed Mental Hy arked oth	ပ္	Walter Vi	iers							orie Pei			
Baltimore, Maryland	and 2 should Health and Me em 27 is marl		19a. Informant's Name/ Luther Fu		<sub>oe, Print)</sub> Husb	and	19b. Mailin					-	r Town, State, Zi . 21222	p Code)
Jore	nt of H nt of H t: If itel			Cremation 3 🗆	Removal from State		ace of Dispos emetery, crem			Nov	Date ember		ocation - City or	
altin	permit. Page 1: Department of I Important: If it any injury or of		4 Donation 5 21. Signature of Funeral		-	Gar	dens C	Name a	nd Address	of Facility	_2009			Maryland
ä	permit Depar Impor any in		Chit	rony	Cons	rell	uj	995 795	nelly 0 Sol	Funera lers Po	l Home ( int Road	of D	undalk, undalk,	P.A. Md. 21222
- 1	nysician Medical		23a. Part 1. Enter the d shock, or heart fail Immediate Cause (Final disease or condition resulting in death)		a. Liv	20 (	Cirr			such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Examiner				Due to (or as a	conseque	ence of):							
J	ed sit	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or impur	diate 2	Due to (or as a	conseque	ence of):							,
1	be executed sician and burial-transi	ledical Exa	that initiated events resulting in death) Last		Due to (or as a	conseque	ence of):					_		
8760	ificate being bhysicial		IF FEMALE:		u							_		
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pred in the past 12 mg/ht 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ths?	3c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic Other (s)					23d. Date of de Month	livery Day Year
ls, P.O.	iires that th signed by Id be detac	by	Part II. Other significan	nt conditions con	ntributing to death be	ut not resu	Ilting in the un	derlying	cause given	in Part I.	23e. Did to			the cause of death?
Division of Vital Records,	he law require tte has been si vage 2 should	Completed									24a. Was a autop perfor		prior to death?	topsy findings available completion of cause of
tal	ician; The certificate rector, pag		25. Was case referred to examiner?	1	laanital:					of Death (Chec		2)C IV	0 12 163	2,2110
j Vi	Physi r this c ral dire	2	1 ☐ Yes 2 Ø No 27. Manner of Death		ospital: 1  Inpatie		R/Outpatient 28b. Time of		OA Other: 28c. Injury at		ome 5 Resid		Other (Spec	is the pick
ono	ending eath. or: After he fune	ficate	2 Accident	Pending Investigation	(Month, Day	Year)	injury	M	work?	s 2 🗆 No	zod. Describe II	ow injur	y occurred	
Divisi	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page	al Certificate:	3 ☐ Suicide 6 L 4 ☐ Homicide	Could not be determined	28e. Place of Inju building, etc		ne, farm, stree	et, factor	, office		28f. Location (S City or Tow			ral Route Number,
7	he Hospi iin 24 hou he Funer	Medical	(Check 2 ∐ N	Medical Examin	cian: To the best of re: On the basis of exercioner: To the b	amination	and/or investig	gation, in	my opinion, a	death occurred a	t the time, date an	nd place	, and due to the	cause(s) and manner stated.
	Not Not Con		29b. Signature and title of	of certifier 2 HOn	nwi, MI	)		290	License nu	umber 59476		29d. Da	te signed (Month	n, Day, Year)
			30. Name and address o	of person who co	DM , 1m	<u>/</u>	6701	int)	Cho	ven s	Tul,	10.	V50a, 1	NO 21204.
	Stat Registra	_	31. Date filed (Month, Da	2 4 2009	Registral	's Signatu	re Bay	el D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** IMOTHY NOVEMBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1⊠ M 2□ F Director 217-56-6299 58 May 25,1951 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "hadreal Expression and the profiled at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 🕅 No Director Maryland Cecil Co. E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States by Funeral 168 West Main Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XTYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public Public Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Transportation 9 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Rager 2 Lester Felix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 44470 Southington, OH 4020 Helsey-Fusselman Road Lester R. Felix, Jr. (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/21/2009 Towson, Maryland 4 ☐ Donation , 5 ☐ Other (Specify) 21. Signatur Uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the sease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ailure. Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** MYDCARDIAL disease or condition resulting in death) 36 HOUR /Medical Due to (or as a consequence of): Examiner ORONARY A
Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran P.O. Box 68760 Due to (or as a consequence of): Physician/Medical as signed by the attending I IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ¥Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should k 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-OOC

State Registrar JOYCE

31. Date filed (Month, Day, Year)

4940 EASTERN AVENUE BATIMORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

SANCHEZ M.D.

24

NOVEMBER 19, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 22 9:20 p <u>Michael</u> <u>Golightly</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Yea )Ct 27 1 **Funeral** Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Maryland Days Min. 1 ★ M 2 □ F Months Hours Director 442-66-3701 51 )ct Usual Residence of Decedent ral", or items 23a or 28a-f shor Examiner must be notified at 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21040 <u>704 Clover Vallev Court</u> United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2x No Maryland 21215-0036 72 hours after filed within 72 hours afte al Hygiene. I **other than "natural"**, o If Yes, Give 1 ☐ Yes 2x ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Writer and Mental Hygie is marked other Car Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ traumatic <u>Travis Emory Golightly</u> Rosalie Dolorosa Whitener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health an Important: If item 27 is any Injury or other trau once. 704 Clover Valley Court, Edgewood, Maryland 21040 Kelly L. Seman/ Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) November Metro Crematory, 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremtion Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition nunths Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or se a consequence oi): If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Peath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Sign ture and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

egistrar's Signatur

escia.

N. Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

November 23 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GEURGE Physician/ RNAKD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 202 Rushley Road Arnold Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Days oct. 2. 1934 Months Hours Director 215-30-7908 75 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Anne Arundel Maryland Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 Rushley Road 21012 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas George Mary Giessel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Hormel/Daughter 202 Rushley Road, Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 23. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 <u>Frederick Road, Baltimore, Maryland 21228</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Physician⊭ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident 1 Yes 2 No investigation after death 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License numbe

State Registrar 31. Date filed (Month, Day, Year)

EFENSE

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:39 A Sandra Lee Gardner Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Stella Maris Hospice Center Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 25,1956 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 Director 215-50-3657 Maryland 53 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10c, City, Town or Location 10d. Inside City Limits Director Dunda1k Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1729 Stengel Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin 1 Never Married 2XXMarried Completed by 1 Yes 2 Y If Yes, Give Year or Dates. 21215-0036 2**XX**No 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced White 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Betty Jean Graves Troy Craven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Stanley A. Gardner (Husband) Dundalk, Maryland 1729 Stengel Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation € ☐ Other (Specify) Hilltop Service Corp. 11/27/2009 Towson, Maryland Fineral Service Licenses Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, <u>7922 Wise Ave.</u> Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BREAST CANCER disease or condition Medical resulting in death) Examiner Examine

4:00 а.ш.

NOVEMBER

the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 SANDRA GARDNER

Be Completed by Physician/Medical

Medical Certificate: To

Commentally that over this over	bue to for as a consec	quence oi).							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imply) that initiated events	Due to (or as a consec								
resulting in death) Last	Due to (or as a consequence of):  d								
IE EENAN E		-			<u> </u>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome of pregn 1  Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌 Ecto	opic pregnancy er (specify)		23d. Date o Month	,			
Part II. Other significant conditions of	ontributing to death but not re	sulting in the underly	ying cause given in Part I.	23e. Did	tobacco use contribu	te to the cause of death?			
		_		1 [	Yes 2 No 3 [	☐ Probably 4 ☐ Unknown			
				per	topsy prio rformed? dear	e autopsy findings available r to completion of cause of th? Yes 2 \( \sum \) No			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing	Home 5 Re	sidence 6 🛣 Other (5	Specify) HOSPTCE			
27. Manner of Death  1 ▼ Natural 5 □ Pending 2 □ Accident Investigatio 3 □ Suicide 6 □ Could not be		28b. Time of injury	28c. Injury at work?		e how injury occurred				
4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif				ation (Street and Number or Rural Route Number, or Town, State)				
(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examination se <b>Practioner:</b> To the best of materials.	on and/or investigatio	n, in my opinion, death occurred	at the time, date	e and place, and due to	the cause(s) and manner stated			
29b. Signature and title of gertifier			29c. License number		29d. Date <b>≴igne</b> d (M	9d. Date signed (Month, Day, Year)			

TIMONIUM, MD 21093

State Registrar 2300 DULANEY VALLEY RD

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**JONES** 

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Grace Giles 2140 AM Novembe 21, 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Genesis Multimedica l'enter Baltimore Towson, maryland 21204 | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4-16-1926 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 □ M 2 🗙 F Months 217-24-7695 83 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD XXYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2548 W. Pratt Street 21223 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed ADivorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Planned Parent Office Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12th grade year School Crossing Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Henry Sarah Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Giles-Son 1330 Laurens St Apt 006 Balto, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Woodlawn Cem 11-28-09 Balto, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H B l an 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrhythmia Daws-hours disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must by notified at

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I're IM.

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Division of Vital Records, P.O. Box 68760.

Physician/Medical Be Completed by

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Certification: To within 24 hours after death To the Funeral Director: Medical

	Part II. Other significant conditions contributing to death but not resulting in the underlying	23e. Did tobacco use contribute to the cause of death?					
1	History of Pulmonary Embolism and refus	sed anticoaquelet	n 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown				
П	- Chronic Obstructive Pulmonary Disea: - Dementia with new onset dysphagia 11		24a. Was an autopsy performed?  1 Yes 2 Ao  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No				
-	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of Death	(Check only one) e 5 ☐ Residence 6 ☐ Other (Specify)				
	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day, Year) (Month, Day, Year)  M  28b. Time of Injury Injury  M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred				
	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office 28	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
-	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investigation and manner stated.	rred at the time, date and place, a ation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)				
ľ	29b. Signature and title of certifier	29c. License number	29d Date signed (Month Day Year)				

29d. Date signed (Month, Day, Year)

State Registrar

Genesis 31. Date filed (Month, Day, Year) NOV 24

1 Center 7700 York Road Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek, CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37567 Certificate of Death Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 07:55 A M Wesley 2009 NOV /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Rallimore Medical Conter Baltimore VA If Under 1 Year | If Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at BaltiMore Yes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XiYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Xterminator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ပ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route N mber, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau
once. 20b. Place of Disposition (Name of cemetery, crematory or other, place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DOXIC /Medical Due to (or as a consequence of): Examiner ncumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trans and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy øerform*e*d? Hospital or Attending Physician: The 1 □Yes 2 ☑No Division of Vital 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural n 24 hours after death.

Ne Funeral Director: After the furble of the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

32. Registrar's Signature

29c. License number

10 North Greene St.

AU4176435P18981

29d. Date signed (Month, Day, Year)

Baltimore, MD 21201

21,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William Grasham 20 10:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Upper Falls 11525 Franklinville Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Feb 6, 1925 7. Age (In yrs. last birthday) **Funeral** Months Country) Va Days Hours Min. 1X M 2 □ F Director 227-28-4514 84 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Baltimore Upper Falls 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any lighty or other traumatic event, the Medical Exempted 2008. USA 11525 Franklinville Road 21156 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★TYes 2☐No 1948 If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify Completed by Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Business Exterminator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Maude Walker Carl Leslie Grasham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21156 11525 Franklinville Road, Upper Falls, Md. John Grasham/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 11/23/2009 Bayview Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licenses 9705 Belair Road, Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed PERLIPIDEN burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed spital or Attending Physician: Ti hours after death. Ineral Director: After this certificat y filled in by the funeral director, pa 1 ☐ Yes 2 No 2 1 No 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Yes à No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Ould not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

DULLA

4924 Campbell Blid

29d. Date signed (Month, Day, Year)

and manner stated.

Ma, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Andrew Gram State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day November 18, 2009 0202 hrs Kenneth Andrew Gram **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel S. Cherry Grove Rd @ Skippers Lane Annapolis | If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Months | Days | Hours | Min. | 08/30/1987 | Foreign | CA 7. Age (In yrs. last birthday) 5. Social Security Number 608-01-6145 **Funeral** 

Director			1/2	M 2 F		Yrs.							
	ı	Usual Residence of Dece	edent										And Incide Objections
nd show any ce.			San D	iego		own or Location							10d. Inside City Limits  1 Yes 2 No
1 with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 3921 May	Court				10f. Zip Co 920	08				izen of What Cour USA	ntry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marke event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2		If Yes		uban, M	lexican, Pue	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ameri White, etc. Whit Specify:	ican Indian, Black,
hours aft natural" Zxamine	ed by	15. Decedent's Educati	tion (Specify o	l or Dates: nly highest grade con		6a. Decedent's during mos	s Usual Oc	cupation		of work done retired)		Kind of Business/	
1036 vithin 72 ene. er than "	Completed	Elementary/Secondar		College (1-4 or	OT)	Poet		<u> </u>		(F)		Artisti	ıc
21215-0036 uild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First John Gra	ım						Da	ame (First, Middl wn Mar:	ie M	lackey	
MD 21 nd 2 should I ulth and Mer m 27 is man		19a. Informant's Name/F John Gram	Relationship (7 1/Fath	ype, Print ) <b>er</b>		19b. Mailing 3921	Address May	Street a	nd Number Car	or Rural Route P 1sbad,	CA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours al Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Melical Examin		20a. Method of Dispositi  Burial 2 Co  Donation 5	Cremation 3	Removal from St	ate Che s		e Cr	em.		Nov. 20	J'¦Be	Location - City or	le, MD
Baltir permit. F Departme Importai		21. Signature of Funeral	Service Licer	see		0/	I/ G	ree	II Ia	Stures	DL.	Darto	rmann P.A. , MD 21286
Physician i I		23a, Part I. Enter the dis failure. List only or	ne cause on e	ach line.		o not enter the	e mode of	dying, su	ich as cardi	ac or respiratory	arrest, sh	nock, or heart	Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final or condition resulting in		Multiple Stab V									
	iner	Sequentially list condition if any, leading to immediate. Enter Underlyin	diate 13 Cause	Due to (or as a cons	equence of):								
nd nd ransit	Examiner	(Disease or injury that in events resulting in deat		Due to (or as a cons	equence of):	:							
exec an ar	dical	UNPENDED		AMENDED									
Ox 6876 eath certificat attending ph	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Aprenant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  9 Unknown												
Vital Records, ysician: The law require linis certificate has been signised on page 2 should b	lete									— р	Vas an utopsy erformed' es 2	prior to death?	outopsy findings available completion of cause of
tal Rection: The certificate ector, page	Be C	25. Was case referred t					26			eck only one)			
Vita hysicia this ce Il direc	0 8	examiner?	No	Hospital: 1 Inpati	ient 2 E	ER/Outpatient	3 DO	A O	other 4 N	ursing Home 5	Resi	dence 6 🗸 Oth	er: Scene
on of \ on of \ ath. ath. r: After tl he funeral	Ä:	27. Manner of Death  1 Natural 5	Pending	28a. Date of In (Month, Day Nov 18, 200		28b. Time of Ir 0202 hrs	· ·	_	at Work? es 2 ✔ No	Subject		njury occurred	
Division its after destrained in Subjects of the Interctory in Interctory its after destrained in by the Interctory its after it	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1. Specify Local Street 1. Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State) 5. Cherry Grove Rd @ Skippers Lane, Annapolis, March 1. Could not be determined 4. Accident 1. Specify Local Street 1. Could not be determined 4. Could no											
Division of Vital Rec inthe Hospital or Attending Physician: The rithin 24 hours after death. of the Funeral Director: After this certificate ompletely filled in by the funeral director, page	edical C	29a. Certifier	rtifying Physi dical Examin	cian: To the best of a	amination an	e, death occur id/or investigat	red at the t	ime, date	e and place death occur	, and due to the red at the time,	cause(s) date and (	and manner as sta place, and due to	ated. the cause(s)

State Registrar DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day Year)

30. Mame and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar s Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08981 State of Maryland / Department of Health and Mental Hygiene Michael Brian Gold Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1140 hrs 2009 November 19, **Medical Examiner** MICHAEL BRIAN 4b. City, Town, or Location of Death c. County of Death 4a, Facility Name (if not institution, give street and number) **Baltimore County** Randallstown 4106 Turf Run Circle If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Davs Hours Min. Director 03-22-1980 215-11-2520 1X X M 29 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County any Yes 2 X X No s 23a or 28a-f show a notified at once. BALTIMORE MD RANDALLSTOWN Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4106 TURF RUN CIRCLE USA 21133 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XXNever Married 2 XX No Yes Yes, Give Year 1 Yes 2XX No specify: Specify: WHITE Widowed Divorced Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) t. Pages I and 2 should be filed within 72 I truent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "rior other traumatic event, the Medical E. Baltimore, MD 21215-0036 4 OWNER ONLINE RETAIL SALES 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **EVELYN** Be ASH GOLD ANDREW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4550 CHAUCER WAY, #205, OWINGS MILLS 21117 EVELYN PRICE/MOTHER 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition

1 X Burial 2 Crer crematory or other place) Cremation 3 Removal from State 11-22-2009 | BALTIMORE. HEBREW YOUNG MEN Donation 5 Other Specify: 22. Name and Address of Facility SOL LEVINSON & BROTHERS, Sign tur f Funeral Service Licensee INC. 8900 REISTERSTOWN ROAD, PIKESVILLE Approximate Interval or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Heroin intoxication Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pue 18 per fh g897 11-24-09 vt 23a,27,28a-f,perME, g898 12/4/09 TT sician/Medical X UNPENDED X AMENDED attending physician or use as the burial 23a,27, Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 3 Ectopic pregnancy Year Day 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 ned by the att detached for 1 Yes 2 No 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown <u>S</u> Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? No 1 🗸 Yes ✓ Yes 2 No page certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Division of Vital Be Other: examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: Yes 2X No Natural thin 24 hours after ceath.

the Funeral Director: Ampletely filled in by the fu Pending 11/19/09 Fd2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 or Town, State) Suicide 4106 Turf Run Cir. Randallstown house determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 20, 2009 O.C.M.E.

State Registrar

**ORIGINAL** 

ark

Assistant Medical Examiner

gistrar's Signatu

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2509 Physician /Medical NEYEmbe (5105) lerome b 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 212-30-6963 02-27-1934 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h Count 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No **Funeral Director** MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? or items 23a or 3501 MIDFIELD ROAD 21208 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYMAN **GROSS** MARY SHALOWITZ ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA GROSS/WIFE Department of Health Important: If item 27 any injury or other tr once. 3501 MIDFIELD ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11-18-2009 BALTIMORE, MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ancrea denecarcidoma Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2**X** No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has page ; 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 1 Inpatient 1 🗌 Yes 3 🗌 DOA 2 ER/Outpatient 5 🗌 Residence Certification: To 6 Other (Specify) After this 27. Manner of Deat 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending Investigation 1 Yes 2 No 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed Director: A vithin 24 hours are
To the Funeral Dir

> State Registrar

Medical

Dalagisi 31. Date filed (Month, Day, Year)

29a. Certifier

(check only one)

29b. Signature and title of certifier

dana van 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

andal

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year,

600 North Wolfe St, Baltimore, MD, 21287

			For State Registrar	State of Ma	aryland	d / Dep Ce	artment of I rtificate of I	Death		giene Reg. No.		37573
	Physicia		1. Decedent's Name (First, Middle, L	•	SMITH	1			2. Date of De Month NOV •		<sup>y</sup> 2009 <sup>Year</sup>	3. Time of Death 8:05 A M
	Medic Examin		4a. Facility Name (if not institution, g	ve street and number)	511111	<u>'</u>		r Location of Death		4c.	County of Death	
	Funeral		Social Security Number     6			st birthday)	If Under 1 Year Months Days	OWSON  If Under 24 Hrs.  Hours Min.		:h		olace (State or Foreign
	Director	L	577-36-2421  Usual Residence of Decedent  10a. State 10b. County	^^	79	Yrs.			27287	1930		INGTON.DC
	/laryland // Ba-f sh tified a	Director	MD BALTI	MORE	10c. City	, Town or Lo	INGS MIL	LS			1	0d. Inside City Limits 1 ☐ Yes XX No
	ith the N 23a or 2 st be no	ral Di	10e. Street and Number 9911 MIDDLE MIL	I DRIVE			10f. Zip Code 21117			10g. Citizen of What Country?		
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	/ Funeral	11. Marital Status	12. Was Decedent E Armed Forces?			Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Americ Black, White,	
21215-0036	urs after tural", o al Exam	ted by	1 ☐ Never Married 2√√√ Marrier 3 ☐ Widowed 4 ☐ Divorced	Year or Dates.	No		1 ☐ Yes 2🏋 XNo	Specify:			Specify: W	HITE
215-	in 72 ho e. nan "nat Medica	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	+)	(Give	dent's Usual Occup kind of work done ( O NOT use retired)	during most of wor	king	16b. Ki	ind of Business Ind	dustry	
	led with Hygien other ti ent, the	Be Co	17. Father's Name (First, Middle, Las	2	<u></u>	NAVAL	. INTELLI		ne (First, Middle,			VERNMENT
rylan	12 should be filed atth and Mental Hyg 27 is marked oth r traumatic event	17. Father's Name (First, Middle, Last)  ABE  GOLDSMITH  18. Mother's Name (First, Middle, Maiden St  EVA  WEINE										
, Ma	and 2 sho Health and em 27 is I	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To  9911 MIDDLE MILL DR; OWINGS MILLS, M										,
nore	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition  1 ☐ Murial 2 ☐ Cremation 3	Removal from State	Ce	emetery, crei	psition (Name of matory or other place	•	Date		ocation - City or To	
PROPERTY OF THE PROPERTY OF TH										0N &	BROS	INC.
	40 = 10 O		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused	the death	185	<del>'UU KEISI</del>	<del>eksiuwn</del> i	<del>(U: BALI</del>	TIMOR	E, MD 21	Approximate
P	nysician/ Medical	8 5	Immediate Cause (Final disease or condition resulting in death)	a. Ly My	Hon							Interval Between Onset and Death
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38760	rrificate ling phys e as the	/Medi	IF FEMALE:	d.				-				
Box 687	To the Fospital or Attending Priysician: The law requires that the death certificate be executed within 24 does after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	cy		1 2	23d. Date of delive Month	ery Day Year
ds, P.C	equires that is an signed to a detail	by	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did to			ne cause of death?
Division of Vital Records, P.O.	sician: The law re certificate has be irector, page 2 sh	Completed	25. Was case referred to medical						1 🗆 Yes		prior to con death?	osy findings available mpletion of cause of
Vita Vita	nysician: his certific tl director,	To Be	examiner? 1  Yes 2 No				nt 3 🗆 DOA Oth	ace of Death <i>(Ch</i> e er: 4  Nursing H		lence 6	Other (Specify,	hospile
on of	nding Path. r: After tie funera	Certificate:	27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigat		Y Year)	28b. Time of injury	work	yat k? Yes 2 □ No	28d. Describe h	ow injury	occurred	
isin	or Atter de after de Directo	Certif	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ry - At hor . (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		d Number or Rural	Route Number,
	In the Hospital or Attending Physical Within 24 hours after death.  To the Funeral Director: Affer this completed filled in by the funeral di	Medical	(Check 2 Medical Exa	nysician: To the best of a miner: On the basis of ex urse Practioner: To the b	amination	and/or inves	tigation, in my opinio	on, death occurred	at the time, date a	nd place,	and due to the cau	use(s) and manner stated.
,	Io th withii To th co可p	~	29b. Signature and title of certifier	w			29c. License	8303	1		e signed (Month, L MBEL H	
			30. Name and address of person wh	o completed cause of de	eath (Item :	23a) (Type, F	Print) Charles			1.000	AT (1901 - 0")	
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			For State Registrar	State of	Maryland	d / Dep <i>Ce</i>	artment of F ertificate of	lealth a D <i>eath</i>	and Mental	Hygier Reg. 1	ne 2009	37574
	Physicia	an	Decedent's Name (First, Mid	ldle, Last)					2. Date Mont	of Death	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institut	Reba		ıckeb	a 4b. City, Town, or	r Location of	f Death		4c. County of Death	10:30 PM
	Examin	er	Bel Air Health a			Center	Bel Air				Harford	d
	Funeral Director		5. Social Security Number 220–22–6892	6. Sex 1 ☐ M 2 🛣 F	7. Age <i>(In yrs. la</i>	st birthday Yrs.	Months Days	If Under 2 Hours	Min. 8. Date (Monitor) Aug	of Birth h, Day, Yea	9. Birth Cou 1919 Al.a	nplace (State or Foreign intry) abama
	ס		Usual Residence of Decedent				<u> </u>		Aug	. 209		
	death with the Maryland rms 23a or 28a-f show r must be notified at	'n	10a. State 10b. Coun	ty	10c. City,	Town or L	ocation	_				10d. Inside City Limits 1 ☐ Yes 2X No
	the M 28a-f notifie	Director	MD 10e. Street and Number	Harford			10f. Zip Code	Jarre	ettsville		Citizen of What Cou	intry?
	h with 23a or st be	al Di	4037 Federal	Hill Road			21084	<b>'</b>		τ	Jnited Sta	ites
	tems termu	Funeral	11. Marital Status	12. Was Dece Armed For		. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Orig	gin? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race - Amer Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ M 3 🕅 Widowed 4 ☐ Divorce	If Yes Giv	e		1 □Yes 2X No	Specify:			Specify: Whi	ite
2-00	72 hou natura lical E	eted	15. Deced	ent's Education hest grade completed)		16a. Dec	edent's Usual Occup	ation during most	of working	16b.	. Kind of Business/Ir	ndustry
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/lan	uld be Mental rked c	To Be	Eddie Clemm	ons				De1	la Brune	r		
Maryland	2 short and 1 is ma		19a. Informant's Name/Relatio				ling Address <i>(Street</i> 37 Federal				ty or Town, State, Z tsville,	
e,	1 and Health em 27	14	Inez Caruso ( 20a. Method of Disposition	Daughter)	20b. Pl		position (Name of ematory or other place		Date		LSVIIIE, Location - City or T	
mor	Pages nent of nt: If it		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		state		ematory or other plac zen Cemet 6		11/25/20	09	Glen Burn	nie, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified at once.		21. Signature of Funeral Service		010		22. Name and Addre	ss of Facility		of Du	ındalk, İr	nc. 1222
	422 60	i la	23a. Part 1. Enter the disease, shock, or heart failure.	complications that	used the death	. Do not e	Juda-Ruck 7922 Wise nter the mode of dyli	Ave.	Dundal  #ardiac or respirar	tory arrest,		Approximate
<u></u>	Physician		shock, or heart fallure. Immediate Cause (Final disease or condition	st only one cause 7 e	ich line.	11/	scerla	N.	1.6	1		Interval Between Onset and Death
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8760,4	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to	or as a consequ	ence of):						
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	Physer this earl dir	1: To	1 Yes 2 No 27. Manne of Death	28a. Date		28b. Time	of 28c. Inju	JALI NU			e 6 ☐ Other (Special of the following o	oify)
岩点	Attending F r death. sctor: After by the funera	atio	Z L / Noorderit	stigation	h, Day, Year)	Injury		k? Yes 2 □ I	No			
) ivis	or Atter de after de l'Directo	Certification: To	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rminod   Zoe, Flace	of Injury - At hor ng, etc. (Specify	me, farm, s	treet, factory, office		28f. Loca City	tion (Stree or Town, S	t and Number or Ru tate)	ral Route Number,
8	spita ours neral			ying Physician: To the								
22	To the Hos within 24 h To the Fur completely	Medical	29b. Signature as inte of certi	and man	ner stated.	ion and/or	29c. Licens				Date signed (Month	
	70 Wil		250. Olynakire data nie olycerii	Do mal	2		He	907	7-7	10	Wess Co	7.3 7.309
			30. Name and address of person	on who completed caus	e of death (Item	23a) (Type	Print)	100		1		0000
			Veken (slove	20 D	Dietrar's Signat	1110 0	Enke Me	y K	djewid	Mi	77104	0.
	Sta Registr		31. Date filed (Month, Day, Yea	2 4 2009 A	gistrar's Signat	1. 1	parks					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 1 - State Registrar 37575 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3. Time of Death Month **Physician** 4:45 AM borah 1) Magans "/Medical 4a. Facility Name (If not institution, give stree and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR toward 5. Social Security Number 8. Date of Birth Month, Day, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 218-36-2596 Months Days Hours Min 1 M 2 X F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 102 Yes 2 □ No Director HIMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330( Cens 2199 35 A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dyews 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ gers annie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any Injury or other trau Balto. mD 21216 Kevera L triend 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition 1 Burial 2 □Cremation 4 □Donation 5 □ Other ( 3 Removal from State 109 30 5 ☐ Other (Specify) of Funeral Service Licensee 21. Signatu Approximate Interval Between Onset and Death 23a. Part1. Enter the d shock, or heart fai sease, or complications that caused the death. Do not enter the mode of dying, are. List only one cause on each line. cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician la /Medical Due to (or as a cons suence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3☐ Probably 4☐ Unknown 2 🗔 No 1 Tes Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2□ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nersing Home Certification: To 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident s after death. thef 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

5

DHMH 17 Rev 1/2001

Hagans

Ebokah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	Physici		1 - State Registrar  1. Decedent's Name (First, Middle, Last  Kathleen Cecel	NA CONTRACTOR OF THE CONTRACTO	* Cei	tificate of	Death	2. Date of Month Octobe	Day	y Year	3. Time of Death <b>10:00 p</b> M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of stown		4c.	County of Deat	
	Funeral Director		5. Social Security Number  215–86–0370  Usual Residence of Decedent	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of (Month) 8—4—1	Birth Day, Year) <b>968</b>	9. Birt Co <b>Mary</b>	thplace (State or Foreign ountry) Land
	e Maryland Ba-f show	ctor	10a, State MD 10b. County PG	10c. City, To		cation Heights					10d. Inside City Limits 1X Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 6814 Drylog Street			10f. Zip Code 20743			10g. Citi	izen of What Co	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at 2006.	by Funeral Director	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	,	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N	ban, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: <b>B</b> ]	e, etc.
21215-0036	1 within 72 ho piene. r then "netur The Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) <b>9th</b>	(1-4or 5+)	(Give life. l	dent's Usual Occi kind of work don DO NOT use retir Worked	upation e during most o red)	of working	16b. Ki	ind of Business	Undustry  Worked
Maryland 2	uld be filed fental Hyg rkad othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  Martin Alexande	er Howard				s Name (First, Mid 1ia Ann 1		Sumame)	
	alth and No. 127 is mail		19a. Informant's Name/Relationship (T) Cecelia Howard					or Rural Route Nu			
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	tery, cren	sition (Name of matory or other pl Cemetery	10	Date /10/2009		ocation - City or lover, 1	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens  James Lincoln					D.L. McLa	_		
	Priysician /Medical Examiner	ılner	23a. Part1. Enter the disease, or complished, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury)	ications that caused the death. Done cause on each line.  a	(C) la f):	er the mode of dy	_	ardiac or respirator			Approximate Interval Between Onset and Death
68760,	ertificate be executed ding physician and se as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):							
×		by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal dea 4  Pregnant at time of death 9  Unknown	th 3 [	Ectopic pregnan	icy		-	23d. Date of de Month	livery Day Year
rds, P.	quires that I n signed by ud be deta		Part II. Other significant conditions co	ntributing to death but not resulting	in the u	nderlying cause g	given in Part I.	- 11	id tobacco t	_	o the cause of death?
Division of Vital Records, P.O. Bo	To the Hospital or Attending Physicien: The law requires that the death within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	Completed						24a. W at pt 1 □ Ye	utopsy erformed?	death?	utopsy findings available completion of cause of
Vita	sicien: certific irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	\t=ation	it 3 DOA		f Death <i>(Check on</i> ing Home 5 ☐ R		€ □Other (See	aibs)
on of	ding Phy Ih. After this funeral d	tlon: To	27. Manner of De th  1 Natural 5 Pending  Accident investigation		Time of Injury	28c. Inj W	71	28d. Descri			uyy
Divisi	al or Atten after dea I Director d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office	9		n (Street an Town, State		ural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death and/or inv	n occurred at the vestigation, in my	time, date and opinion, death	place, and due to to occurred at the tin	he cause(s) ne, date and	) and manner as d place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and fittle of certifier			29c. Lice	1257	48	29d. Da	te signed (Mont	h, Day, Year)
_			30. Name and address of person who co	ompleted cause of death (Item 23a	NT (TYGO.	Print Plas	5748			1	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 4 2009	32. Registrar's Signature	bank	lad					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Hawkins 11: 45 AM Louise 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🔀 F 81 Yrs 9, Director 220-24-7227 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location injury or other traumatic event, the "tedical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Holmehurst Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 MNo 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Be Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell W. Sapp Louise Owens ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Hawkins, Jr. Husband 50 Holmehurst Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11/27/2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee W01050 Funeral Home of Catonsville, 1630 Edmondson Avenue; Caton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville. MD 21228 Immediate Cause (Final **Physician** Bladder carcinom disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 □ Yes 2 **⊡**′No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11/21/09 D0057465 MS KYUPENOR MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Mainst , Suite 200, Reisterstown, MD. 21136 N.S. Rajapakse, M.D

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2 4 2009

P.O.

32. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Records, certificate Vital Division of

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** FREDERICA HEINSTADT 21, 2009 P M 1:45 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 9. Birthplace (State or Foreign Country)
Mary Land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MArch 8, 1936 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Days 1□ M 2/XF Months Hours 212-34-8009 73 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f shorevent, the Madical Examiner must be notified at XXYes 2□No Director Maryland None Baltimore 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 6109 Chinquapin Parkway 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2**X**X√lo Specify: ð Specify. 3 Widowed 4 X Voivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event. In a landary once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick John Havecker Helen Elizabeth Krohne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jennifer H Heinstadt DTR 20 Gwynnbrook Avenue Owings Mills Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State GreenMount Crematory Nov 24, 2009 |Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funera 22. Name and Address of FaMiltchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care Immediate Cause (Final **Physician** ventricular disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 1 Yes 2 Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign I be cate has been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending 1. Natural 5 | Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🕮 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number e of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2009 **Physician** 20, Santa Josephine Hogan 6:00 pM November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rosedale 8100 Timberbrooke Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last hirthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☑ F 84 219-14-0580 Director Balt., Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location. 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinating an author traumatic event, Ite Medical Examinating and Rosedale 1 □Yes 253No Director Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 8100 Timberbrooke Road 21237 Funeral America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 3 ☐ No Specify: þ 3☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Domenic Ravita Antoinette Ponticello ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose F. Ravita/ sister 8100 Timberbrooke Road Rosedale, Maryland 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) November Cemetery 24, 2009 | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Dat 24, 2009 21. Signature of Fineral Service ofeto 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ton disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician end s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending I 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 sl 24a. Was an autopsy performed 1 Yes 2 No Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hou To the Funer completely fil Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/23/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUCHR. WIRS, MO; 9103 Frankin Star Dive, Suk 300, Beh noc, M9 2123 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37581 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy Elizabeth Scheiner Hemerich Nov 2*0*0' /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner ST. AGNES BALTIMORE HOSP ITAL If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🙀 F 214-18-6158 87 Director November 2, 1922 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Evan. 1 ☐ Yes 2 ☐ No MD Baltimore Catonsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21228 USA 111 Oella Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 72 hours after 1 ☐Yes 2**X**If Yes, Give
Year or Dates: 2**X** No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 k Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory Assembler Western Electric 9 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Ruehling Edward C. Scheiner ပ Department of Health and Important: If item 27 is ma any injury or other traumat once. and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 Oella Avenue Catonsville, Maryland 21228 Anthony Dalfonzo Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park Nov 23, 2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. Licensee 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MEUMONIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 m htths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 IPNo 24a. Was an has autopsy perform 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No I or Attendi after death. Director: A 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

SQUITHCATONAVE BALTIMORE MUZILY

32. Registrar's Signature 31. Date filed (Month, Day, Year)

			For State Registrar	State of	Marylan		ertment of F		Mental Hy	rgiene Reg. No. 20	109	37582
	Physic		1. Decedent's Name (First, Middle,	Last) aki	Ishi	moto	<u> </u>		2. Date of De Month Novem1		Year	3. Time of Death 5:00 P M
	/Med Exam		4a. Facility Name (If not institution, 8101 Connectic	-	nber) #C304		4b. City, Town, or Chevy	Location of Dea		4c. County		<u> </u>
	Funera Directo		560-26-1247	6. Sex 1 □ M 2XQXF	7. Age ( <i>In yr</i> s. i 90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year) 1919	Coun	olace (State or Foreign ntry) ifornia
	Maryland -f show	tor	Usual Residence of Decedent	gomery	10c. City	y, Town or Lo	cation Chevy C	hase			1	0d. Inside City Limits 1 ☐ Yes 2 🛣No
	th with the 23a or 28a	ral Director	10e. Street and Number 8101 Connectic	ut Ave.			10f. Zip Code	0815		10g. Citizen of Unite		*
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nutfined at more.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes If Yes, Give Year or Da	ces? 2 XNo e		Vas Decedent of H fYes, specify Cuba I∐Yes 2ѬNo	lispanic Origin? ( an, Mexican, Puer Specify:	Specify Yes or Norto Rican, etc.)	o- 14. Rad Bla Specif	ce - Americ ck, White, e	
	Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examination of the present of the Medical Examination of the present of the Medical Examination of the present of the Medical Examination of the present of the Medical Examination of the present of the Medical Examination of the present	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	4or 5+)	(Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	during most of wo d)	orking	16b. Kind of B		
	land 2:	To Be Co	12 17. Father's Name (First, Middle, L. Masuji	ast) Tom	Asak		drobe Mi		me (First, Middle		-	Dance
	and 2 shou ealth and N n 27 is mar	-	19a. Informant's Name/Relationshi Roger A. Ishim			7704	g Address (Street Beech Tr	ee Rd.,		a, MD 2	0817	
	Baltimore permit. Pages 1 Department of H Important: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Control o	ecify)	Che	sapeak	sition (Name of natory or other place ce Cremat	ory   Nov		20c. Location Be1tsv	ille,	
	Dad permi Impor		21. Signature of Funeral Service Li		MC163	9	Name and Addre Rapp Fune 33 Gist	Ave., Si	lver Sp	ring, MD	ces 20	)910
£ (	Physician /Medical	-	shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea	diac Ar	rhythm		ig, edon de cardio	to or roopilatory t			Approximate Interval Between Onset and Death
100 5 P	8760, Cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if am leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyp  Due to (c	otensic or as a consequ or as a consequ	on uence of):						2 hours
M/20/09	O. Box 6 he death certifi re attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fetal ant at time of d	death 3	Ectopic pregnanc Other (specify)	у			ate of delive	ery Day Year
Dod	cords, P. w requires that the speen signed by should be detacted.	þ	Part II. Other significant condition  Methicillin s			-				tobacco use con	tribute to th	ne cause of death? Dably 4 ☐ Unknown
0	Vital Recosician: The law rector, page 2 sh	Completed							1 □Yes	opsy ormed? 2 X No	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2  No
TSHEM1040	Division of Vital Records, or Attending Physician: The law requires that death.  Director: After this certificate has been signed in by the funeral director, page 2 should be to the funeral director, page 2 should be to the funeral director.	ion: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date o	npatient 2 🗆 of Injury h, Day, Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Worl	er: 4 □ Nursing y at k?	Home 5 K Res 28d. Describe			(y)
#st	Division of To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director and the state of the funeral director.	Certification: To	2  ☐ Accident investiga 3  ☐ Suicide 6  ☐ Could no 4  ☐ Homicide determin	4.1	of Injury - At ho g, etc. <i>(Specif</i> )	me, farm, stro	M 1 □ eet, factory, office	Yes 2 □No	28f. Location City or To	(Street and Num wn, State)	ber or Rura	al Route Number,
MAY	the Hospit hin 24 houn the Funera	Medical C	(Check only 2 Medical E	Physician: To the la xaminer: On the ba and mann	sis of examina	wledge, death tion and/or in	vestigation, in my o	ppinion, death occ	ce, and due to the curred at the time	, date and place,	and due to	o the cause(s)
		Z	29b. Signature and title of certifier  • hleua f. ×  30. Name and address of person w	Lhapiw,		1 23a) (Type.	29c. Licens D35			29d. Date signe		Day, Year) 23, 2009
	Sr. Regis	tate	Deena J. Shapi 31. Date filed (Month, Day, Year)	ro, M.D.	·	) Conne	ecticut A	ve., Ker	sington	, MD 20	895	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** 5:10 p м Howard Julius Jenkins Nov. 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, March 3, Birthplace (State or Foreign Country West If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1X M 2 □ F 97 Virginia Director 213-09-9608 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinary. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Maryland Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 709 Maiden Choice Lane 21228 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2□No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Business Jeweler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Howard Oscar Jenkins ည Edna Rose Kroeger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonita Bannar/ P.O.A 617 Tamiami Trail North Unit 35, Venice, Florida 34285 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 23. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. e of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical Examiner

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

disease of condition	a I HOUMONIO			June
resulting in death)	Due to (or as a consequence of):			7
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):			
Cause (Dissase or figury that initiated events resulting in death) Last	c			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		stopic pregnancy ther (specify)	23d. Date of Month	delivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use contribut	/
			autopsy prior deat	e autopsy findi <i>n</i> gs available to completio <i>n</i> of cause of h? Yes 2 □ No
25. Was case referred to medical		26. Place of Dea	th (Check onl one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: Nursing H	ome 5 Residence 6 Other (	Specify)
27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	A TOTAL CONTRACTOR OF THE PARTY	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
	ysician: To the best of my knowledge, death o niner: On the basis of examination and/or inves and manner stated.			
29h. Signature and title of certifier		29c. License number	29d. Date signed (M	lonth, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours at To the Funeral D completely filled i

dress of person who completed cause of death (Item 23a) (Type, Print)

P8905 D

Maiden Choice Lane Catansville MD

November 21

			Ple	ase Type o					-		gible.	
			1 - For State Registrar	State	of Maryl		artment of ertificate of		i Mental H	ygiene Reg. No. 7	000	07501
			Decedent's Name (First, Mid	idle, Last)			Timodio or	Douir	2. Date of D	eath	. 0 0 9	3. Time of Death
	Physici /Medio		James M. Johns						Novemb	per 22.	Year 2009	10:21 A M
- Marie Co	Examir		4a. Facility Name (If not institu	ion, give street and	number)		4b. City, Town,	or Location of De	ath	4c. Cou	nty of Death	
			Greater Bal	_	_		Towson		rs. 8. Date of B		imore	along (State or Famige
	Funeral Director		5. Social Security Number 212-20-6005	6. Sex 1  M 2  F	7. Age (In	yrs. last birthday Yrs.	Months Days			7, 1925	Coul	olace (State or Foreign ntry) Maryland
			Usual Residence of Decedent		0.				1101	, 1010		
	arylan show	_	10a. State 10b. Cour	,		. City, Town or L	ocation				1	Od. Inside City Limits
	he Ma	Director	MD Balti	more	M	onkton	10f 7in Oada			10 Citivon	of What Cour	1 □ Yes 2 No
	with t		10e. Street and Number 603 Corbett Ro	had			10f. Zip Code 21111			USA	or writer Cour	iti y :
	hours after death with the Maryland tural", or items 23a or 28a-f show at Exeminer must be notified at	Funeral	11. Marital Status	12. Was Do	ecedent Ever i	n U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin?	(Specify Yes or N	L	Race - Americ	
9	or ite	/Fu	1 ☐ Never Married 2 ☐ M	arried 1 X Ye	Forces? s 2 No		1 ☐ Yes 2 X No		erto Hican, etc.)		Black, White, عناندن	
003	ural",	d by	3 🕅 Widowed 4 □ Divord	ed Year o	r Dates:	10. 2					WI	ite
7	in 72 in mat redical	olete	(Specify only hig	ent's Education hest grade complete		16a. Dec (Giv.	edent's Usual Occu e kind of work done DO NOT use retire	upation e during most of v ed)	vorking	160. Kind o	f Business/In	dustry
212	filed within 72 Hygiene. Ither than "na Int, The Wedic	Completed	Elementary/Secondary (0-12	) College	e (1-4or 5+)		Manager			Equipm	ent Le	easing Co.
pu	be filed that Hyging of other event, I	Be C	17. Father's Name (First, Midd						lame (First, Middl	e, Maiden Surr	name)	
yla	should that and Meni	ဥ	James M. Johns					Bertha				
Mar	d 2 sho th and 7 Is ma traum		19a. Informant's Name/Relation		rother	I	ing Address <i>(Stree</i> F <b>lin</b> t Ro					
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygtene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Medical Exament must be notified at		20a. Method of Disposition	15 / L			osition (Name of ematory or other pla		Date		on - City or To	
m 0	Pages nent of ant: If Its ary or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □ Removal fro	m State		ematory or other pla 1ey Mem Gar		/24/09	Timoni	ит МГ	1
altimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury of once.	li	21. Signature of Juneral Pivi	1 -	ψα		2. Name and Addr		24/03			ork Road
<u>m</u>	9 9 E 8 9		) let	Velley			uck Towso				Towsor	n, MD 21204
П			23a. Part 1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause of	at caused the on each line.	leath. Do not er	nter the mode of dy	ring, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	brond		eural	TISTU	1a			
$\forall$	Examiner			Due	to (or as a con	sequente of):	cance	V				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due	ιο (or as a con	sequence of):	Collice					
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	be executed sician and burial-transit		resulting in death) Last	Due	to (or as a con	sequence of):						
687	death certificate t e attending physik d for use as the b	Physician/Medical		d								
Вох	h cert ending use a	IN/III	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		□ c.t:			23d.	Date of deliv	ery
. B	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pr	egnant at time		☐ Ectopic pregnar ☐ Other (specify)				Month	Day Year
P.0	uires that the de n signed by the a id be detached f	Phy	9 ☐ Unknown Part II. Other significant cond			regulting in the	anderlying earlies a	iven in Part I	23e Did	I tobacco use c	contribute to t	the cause of death?
ds,	signe signe d be d	d by	Tartii. Other algiinicant cond	tions contributing to	death but not	resulting in the	andenying cause g	iveiliir aiti.	1	¥es 2□N		bably 4 ☐ Unknown
COL	v req	Completed							24a. Wa	s an 2	4b Were auto	opsy findings available
Re	ician: The law certificate has ector, page 2:	duic							aut per	opsy formed?	prior to co death?	impletion of cause of
		BeC	25. Was case referred to medi	cal				26. Place of D	1 □Yes Death (Check only		1 □ Yes	2 L No
<b>f</b> <	hysica his ce I direc		examiner? 1 Tes 2 No	Hospital:	npatient	2 🗌 ER/Outpatie	ent 3 DOA	ther: 4 🗆 Nursin	g Home 5 ☐ Re	sidence 6 🗆	Other (Speci	fy)
o L	ding Phys h. After this funeral di	:uo	27. Manner of Death		ite of Injury Ionth, Day, Yea	r) 28b. Time Injury	We		28d. Describe	e how injury oc	curred	
isio	ttend death stor: / the f	icati	3 ☐ Suicide 6 ☐ Cou		oo of Injury -	At home farm s	M 1 [	□Yes 2□No	28f Location	(Stroot and No	umber or Pur	al Route Number,
Division of	I or Atten after deatl Director; d in by the	Certification: To	4 ☐ Homicide dete	rmined 200. Fla	ilding, etc. (Sp	ecify)	reet, lactory, office		City or To	own, State)	annoer or man	ar rioute Namber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			ying Physician: To al Examiner: On the								
	the H hin 24 the Fu	Medical	one)	and m	anner stated.				coned at the time			
	<b>5</b> vit	2	29b. Signature and title of certi		)	^	29c. Licer	nse number	12-3	11/7	gned (Month,	Day, rear)
	141.		30. Name and address of pers	on who completed ca	//	(Item 23a) (Time	Print)	00200	0.2	11/2	2/0/	212011
-	HI		Mark G	SAPIL 6	536	No Chu	les N	- Favilli	on Sui	te 55	O TOI	Son MB
		ta	31. Date filed (Month, Day, Yea	(r) A 32	. Registrar's S	ignature -					1	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2057 M Oyster Jones Leonard 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes Baltimore NA Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Experimer must be redified at once. 1 □Yes 2 XNo Director Baltimore Cak 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA Lafayette Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indían, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) Baker Gignt toods 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Altress Jones Marie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Lafayette Avenue Gwynn Daugh Angela M. Jones Ter Dall MD 21207 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State oudon Park Cemetery! Baltimore, MD 09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greine Funer Sentices 21. Signature of Funeral Service Licensee Vauge Road Randall Stown MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septic shock day >/Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) n signed by the a Id be detached fo 9 Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes iis certificate has been s director, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number A524385284106

Leonard Sr

ones,

31. Date filed (Month, Day, State NOV 24 Registrar

apazoglou, MD 900 Caton Ave. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, MD

2009

21229

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** ackson Veria 20 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore St. Agnes Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 M \$7 Yrs. 219-12-6114 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational benefited at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Ballimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 110 Specify If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of wark done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail earnstress 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Num er, City or Town, State, Zip Code) Informant's Name/Relationship 3 Bellmore Rd. Baltimore, ND 21244 Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 22. Name and Address of Facility Voughn C. Groene funeral Stores 1 Burial 2 ☐ Cremation 3 ☐ Removal from State rrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee iberty Rd. Randallstown, No 21133 Approximate Interval Between Onset and Death ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the dise shock, or heart fall ur Immediate Cause (Final disease or condition resulting in death) Physician therasulat raldialastul /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 \( \text{Yes} \) 2 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30 Name and address of per on ho completed cause of death (Item 23a) (Type, Print)

State Registrar 0

31. Date filed (Month, Day, Year)

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NOV 24 2009

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32. Registrar's Signature

Baltimore, Maryland 21215-0036

of Vital Records,

4CKSON,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Kendzejeski Μ. 20,2009 Rose November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Co. Stella Maris Retirement Community
5. Social Security Number | 6. Sex | 7. Age (In yrs. last bird Timonium Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Year) Hours Months Days Min 1 □ M 2 1 F 22,1922 Maryland Director 215-14-9188 87 Jan. Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evant activates to notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Directo Middle River <u>Maryland</u> **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 United States 6604 Blackhead Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Pucci Ann Biscotti 2 19a. Informant's Name/Relationship (Type. Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6604 Blackhead Road Middle River, Maryland 21220 Mr. Francis J. Kendzejeski, Jr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/2009 Baltimore, Maryland St. Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Busculor **Physician** /Medical Due to (or as a consequence of) Examiner 13 Woschio. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of sician and burial-transit that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760. led by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other inficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate Vital 1 □ Yes 2 110 Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of conflier 29d. Date signed (Month, Day, Year) 29c. License number NOVEMBER 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 24 Registrar

DHMH 17 Rev 1/2001

NOVEMBER

erome Kelly	State of Mary 1- For State Registrar	land / Department of Certificate of		ygiene Reg. No	2009 3758
Physician	Decedent's Name (First, Middle,Last)			2. Date of Death  Month Day  November 22,	3. Time of Death
/ledical Examin	J  4a. Facility Name (if not institution, give street and	erome Kelly	b. City, Town, or Location of Death		2009 2040 IIIS
.)	Sinai Hospital	,	Baltimore		
Funeral Director	5. Social Security Number 6. Sex 218-74-9325 1 XM 2 F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year If Under 24Hrs  Months Days Hours Min	<b>→</b>	M/DD/YYYY) 9. Birthplace (State or Foreign Country) 959 MD
8	Usual Residence of Decedent	I I I I I I I I I I I I I I I I I I I	<u> </u>		10d. Inside City Limits
low any	MD N/A	10c. City, Town or Location			1 X Yes 2 No
daryland 28a-f show 1 at once.	10e. Street and Number	Baltimor	10f. Zip Code	10g. Cit	tizen of What Country?
the h			21215		J S A
er death wi	5	Forces? If Ye	Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		. 14. Race - American Indian, Black, White, etc.
after c	3 Wildowed 4 1 Divorced in 195, Give	Year 1	Yes 2 X No specify:		Specify: Black
2 hours "natu			s Usual Occupation (Give kind of st of working life. DO NOT use ret		Kind of Business/Industry
036 ithin 7; ne. r than	2	n/a Disa	bled		Disabled
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical				e (First, Middle, Maide	n Surname)
2121 uld be fi Mental 3 marked	Jerome Kelly, Jr 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Helen Address (Street and Number or	Wyche Rural Route Number, (	City or Town, State, Zip Code) 21239 Balto, MD
MD d 2 sho lth and n 27 is	Kiwana Hill-Sister	1106	E. Beleveder	e avenue	Apt A
Fe, s I and of Heal If iten her tra	20a. Method of Disposition  1 Burial 2 Cremation 3 Remova		tion (Name of cemetery, er place)	Date 20c	c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	4 Donation 5 Sther Specify		ill Cem   11-	-28-09 A	Anne Arundel Co.M
Bal permi Depar Impo	21. Signature of Fund al Service License	22. N   1	ame and Address of Facility Ma .101 E. North		Balto, MD 21202
Physician	23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.				
/Medical  xaminer	Immediate Cause (Final disease a. Complica	ations of Neck Injuries			Death
	h .	s a consequence of):			
	Sequentially list conditions, if any, leading to immediate Due to (or a cause. Error Underlying Cause	s a consequence of):			
wit ed	(Disease or injury that initiated events resulting in death) Last	s a consequence of):		-	
		D.			
60, te be e hysicial e burial		es, outcome of pregnancy		2	23d. Date of delivery
30x 6876 death certificate e attending phy	23b. Was decedent pregnant in the past 12 months?	e birth 2 Fet	al death 3 Ectopic pregn		Month Day Year
Box 68760, e death certificate be the attending physic of for use as the but	1 Voc 2 No 9 Unknown	egnant at time of death 5 Oth known	ner (Specify)		
- 4 Feb 1		g to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
S, P.C					No 3 Probably 4 ✔ Unknown  24b. Were autopsy findings available
cords law requi has been 2 should				24a. Was an autopsy performed	prior to completion of cause of
tal Rection: The certificate ector, page			26.Place of Death (Check	1 <b>Y</b> Yes 2	No 1 Yes 2 No
f Vital Rec Physician: The er this certificate tral director, page	25. Was case referred to medical examiner?  1 Ves 2 No	Inpatient 2 ER/Outpatient	Other		dence 6 Other:
Far Far	27 Manner of Death 28a D	ate of Injury 28b. Time of In		28d. Describe how in Subject struck b	
sion Attendi death. ctor:	Natural 5 Pending Nov 2		1_ Yes 2 ✔ No		
Divis  Divis  pital or At  ours after d  teral Direct filled in by	Suicide Could not be determined	lace of Injury - At home, farm, stree ify) Local Street	et, factory, office building, etc.	or Town, State)	t and Number or Rural Route Number, City and Manchester Street, Baltimore , MI
pospi mer y fil	29a. Certifier	best of my knowledge, death occur	red at the time, date and place, an	d due to the cause(s)	and manner as stated.
To the Hos within 24 h	one) 2 Medical Examiner: On the base	sis of examination and/or investigat	ion, in my opinion, death occurred	at the time, date and p	place, and due to the cause(s)
	29b.,Signature and title of certifier	1	29c. License number O.C.M.E.		d. Date signed (Month, Day, Year)  ovember 23, 2009
	30. ame and address of person who completed of	rause of death (tem 22a)	O.O.IVI.L.		575.HIDGI 20, 2005
			n Street, Baltimore, MD 2	1201	
Sta	ALENT OF A VIOLENCE	Registrar's Signature			
Registr	MILLY 23 9 GUUS CARRE	a postal			2000

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State of Maryland / Department of Health and Mental Hygiene 2009

		•	For State Registrar	tate of Maryland /	Cert	ificate of D	eath		Reg. No.	9 3/589
Ph	nysicia	ın/	1. Decedent's Name (First, Middle, Last)  Albert	Kitchenhar	m			2. Date of Deat Month	Day Yea	
	Medio xamin		4a. Facility Name (if not institution, give street		<u></u>	4b. City, Town, or	Location of Death	November	4c. County of D	eath
-/	ıneral		Gilchrist Hospice  5. Social Security Number   6. Sex	7. Age (In yrs. last b	oirthdav)	Tows	If Under 24 Hrs.	8. Date of Birth	Balti	Birthplace (State or Foreign
	ector		224-58-1286 <sup>1</sup> x M	<sup>2□</sup> F 82		Months Days	Hours Min.	(Month, Day, 7/26/19	Year)	Country) England
land	show d at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Loca					10d. Inside City Limits
e Mary	r 28a-f notifie	Direc	MD Anne Arunde	1		Laurel			10g. Citizen of What	1 Yes 2 No
with th	s 23a o ust be	Funeral Director	3363 Wye Mills	South			724		Engla	
21215-0036 within 72 hours after death with the Maryland giene.	is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	β	1 Never Married 2 Married	Vas Decedent Ever in U.S.  vrmed Forces?  Yes 2 X No Yes, Give ear or Dates.		as Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. White
Maryland 21215-0036 2 should be filed within 72 hours after tith and Mental Hygiene.	than "nath he Medica	Completed	15. Decedent's Educati (Specify only highest grade co		(Give ki life. DO	ent's Usual Occupa ind of work done di NOT use retired) Engineer	ition uring most of worki	ing	16b. Kind of Busine	ess Industry
ind 2 e filed w ital Hygi	event, 1	வ	17. Father's Name (First, Middle, Last)	nham			18. Mother's Name	e (First, Middle, N Florer	/laiden Surname)	
larylar should be and Ment	Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type, P	rint) 1		Address (Street a	nd Number or Rura	l Route Number,	City or Town, State,	Zip Code)
re, N and 2 s Health	item 27 other tra		Trudi Kitchenham Gal 20a. Method of Disposition	20b. Place	2513 of Disposi	ition (Name of	d Knoll		denton, MI 20c. Location - City	
Baltimore, permit. Page 1 and Department of Hea	tant: If jury or		1 ☐ Burial 2 😿 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Final	Journ	ney Crem.		4/2009	Woodbir	
Ball permit Depar	any in		21. Signature of Funeral Service Licensee	prota Marshal Llausua N	22.	Name and Addres		emation	n Servic	es 1D 21203
Piliys		3 33	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition	se on each line.	Nuc	the mode of dying	, such as cardiac d	or respiratory arre	est,	Approximate Interval Between Onset and Death
	edical miner		resulting in death)	Due to (or as cons quenc	e of):	ic syn	dome			years
14 P	nsit	Examiner	Esqueritially list 65 difficus, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequenc	e of):	,				
) se execu	physician and the burial-transit	al Ex	that initiated events c resulting in death) Last	Due to (or as a consequence	e of):					
8760 ificate b	ig physi as the t	Medical	d							
Division of Vital Records, P.O. Box 68760 — To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours, fire death.	been signed by the attending p should be detached for use as	Physician/N	in the past 12 months?	f yes, outcome of pregnancy  Live Birth 2 Fetal de Pregnant at time of death  Nknown		Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
s, P.O.	signed by d be deta	by	Part II. Other significant conditions contribu	uting to death but not resultin	g in the un	derlying cause give	en in Part I.	23e. Did tob	1	e to the cause of death?
Records, The law requires	e has beer ige 2 shou	Completed						24a. Was a autops perfori	sy prior med? deatl	
Vital R ıysician; Th	certificate has t irector, page 2 s	Be Co	25. Was case referred to medical examiner?	<u> </u>		26. Pla	ce of Death (Check		2 <b>S</b> 4No 1 🗆	Yes 2 □ No
of Vit	this al d	욘	1 Yes 2 Xio	1 Inpatient 2 ER/ 8a. Date of injury 28b	o. Time of	3 DOA Othe	4 ☐ Nursing Ho		ence 6 Other (S)	pecify) NOSPICE
Sion C	or Affer the funer	Certificate:	Natural 5 Pending Accident Investigation Suicide 6 Could not be	(Month, Ďay, Year)	injury		? Yes 2□No			
Division of tall or Attending Ph	ed in by the		4 Homicide determined	8e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (St. City or Town		Rural Route Number,
e Hospi	To the Funeral ocumpleted filled is	<b>Nedical</b>	(Check ' 2 L Medical Examiner: C	To the best of my knowledge on the basis of examination and actioner: To the best of my knowledge.	d/or investi	gation, in my opinio	n, death occurred at	the time, date an	id place, and due to t	he cause(s) and manner stated.
Within the A	comp	-	29b. Signature and title of certifier	13		29c. License	number 58303	2	Pgd. Date signed (Mo Novembe	20 0 -
			30. Name and address of person who complete		Parent	int) N. C.	58303 1026, S		70-(5)4	140
	Sta egistr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	5 (01	arkal	VIUS C	1	0142010	VVI)

Examiner Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

physician and s the burial-tran attending I for use as Director; within 24 hours after To the Funeral Discompletely filled in

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show notified at

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"natural", er than "nature the Medical E

other

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permit. Page Department of Important: If any injury or once.

Physician /Medical

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Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Be Completed

Medical Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

29c. License number Dso 641

29d. Date signed (Month, Day, Year) November 20 2009

Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabapathi

201-109

Back River Mcck Road Baltmer Mayland 2/24

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



			State of Maryland / Department	artment of Health and M 1/24/09dhb intlicate of Death	lental Hygie <sub>Reg</sub>	no2009 37591
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 3. Time of Death
-	/Media	al	Philip Henry Knefely		November	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Prince George's Hospital	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	
	Director		579-46-4525 1X M 2□F 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You July 22,	1935 unk
	land bw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary a-f sh	tor	MD Prince George's Hyattsv	ille		1 □Yes 21 No .
	th the	Oire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	s 23a	eral	7001 Castlewood Drive	20785		USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it in Medical Evernins must be multised at once.	by Funeral Director	1 N Never Married 2 □ Married   1 □ Yes 2 N No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ∐Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: black
21215-0036	within 72 ho ene. <b>than "natu</b> i w Medical	Be Completed	(Specify only highest grade completed)   (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	unk 16	b. Kind of Business/Industry uni
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Maryland	2 sho and l			ng Address (Street and Number or Rura		•
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Baltimore,	. Pages tment of tant: If it jury or c	1 13	1□Burial 2□Cremation 3□Removal from State 4□Donation 5▼Other (Specify) in state	matory or other place)		
Bal	permit Depar Impor any in	6 16		alte adages of Facilities and Altimore, MD 2120.		altimore Street
	Physician /Medical Examiner	al Examiner	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate cause (Final disease or continuous cause)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	er the mode of dying, such as cardiac of	or respiratory arrest	Approximate Interval Between Onset and Death
P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  Within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that in signed build be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions.	nderlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
al Records,	Physician: The law re r this certificate has berral director, page 2 sho	Completed	Schuppelley		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
₹ Ki	sician certifi rector,	Be	25. Was case referred to medical manning and the spiral was a spiral w	26. Place of Death		
ō	Phys er this eral di	1:10	27. Manyfer of Death 28a. Date of Injury 28b. Time or	1 3 DOA 4 Nursing Hol	me 5 Residence 28d. Describe how	e 6 ☐Other (Specify)
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Division of Vital	l or Atte after dea Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)
	Hospita 24 hours Funeral etely fille	Medical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of pertifier	29c. License number	29d	. Date signed (Month, Day, Year)
			/ Jolen	\$303/8	8 /	1/12/00,
			30. Name and address of person who completed cause of death (Item 23a) (Type,		7 251	20795
	Sta			1	erly, Md	20703
	Sta Registra		31. Date filed (Month, Day, Year)  NUV 2 4 2005  32. Registrar's Signature			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#28a, perME, G897, 11730709, WS State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Juri Kiima 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8515 Fowler Avenue Baltimore Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours January 31.1937 72 Director 212-34-2220 Estonia Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "maryling or other transman." 10h. County 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8515 Fowler Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 XYes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Exxon Dealer Gas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold Kiima Milda Tanilov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8515 Fowler Avenue Baltimore, Maryland 21234 BettyJo Kiima 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) emetery, crematory or other place. Hilltop Service Corp. 11/23/2009 Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or some cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Shot Wound Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence on Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🗘 Ünknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 **X** No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes ၉ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Selfullicted After November 19,2009 1 Natural 5 Pending work?
1 Yes 平1127 AM 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director; A

Completed filled in by the wound 8f. Location (Street and Number or Rural Route Number, City or Town, State) 8515 Fow len Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) tome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of cent 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Dr. PhillipMilitello 6 TRIMBLE NIPRYLAND 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 37593 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year Month Day Physician Nov.  $2\overline{1}$ 11:35 A.™ Kurt C. Lauritzen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5903 Eric Drive Carroll Mt. Airv If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes July 30, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) <sup>Year</sup>1950 **Funeral** Days 1X M 2□ F 59 Director 213-58-4665 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ural", or items 23a or 28a-f show Examiner must be notified at Sykesville Carroll Maryland 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Streaker Road 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ht: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th self-employed Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lauritzen Marguerite Knight Hermann မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Streaker Road Sykesville, MD Kjeld Lauritzen Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State South Carroll Crematory 11/23/09 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 23a. P. rt1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final dis assor condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinitedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) the attending physician hed for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed?
Yes 2 No certificate has page 2 s 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Friends 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Priph)

NAG TI J. SUREIA MD. 4212 (1) fruinster Md. 21157 SURE 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner The law requires that the death certificate be executed and burial-tra Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10a. State

Director

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, it is Medical Every in a must be notlifted at

Baltimore, Maryland 21215-0036

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Important: If item 27 is
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attending physician for use as the buria ned by the a should be has page 2 s funeral director,

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31. Date filed (Month, Day, Year)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? I∐Yes 2∐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CVCV Lyloz 21 Nivember 200

DHMH 17 Rev 1/2001

Hospital or Attending Physician:

24 hours after deat Funeral Director:

To the I within 2 To the I

completely

Caton Ave

Baltimore MD

900

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

And	lrew Leonar		1- For State	tate of Ma	aryland /		rtment of tificate of			Menta	al Hygi		g. No.	200	0 2750	
Mo	Physic dical Exam	an/	Registrar 1. Decedent's Name (First, Mid Andrew	lle,Last) Leona	rd N	lagi	-					Date of Death Month lovember	h	Year	3. Time of Death 2000 hrs	
í	aloui Exam		4a. Facility Name (if not institut					b. City, To	wn, or Lo	ocation of		overnber	4c. Co	ounty of Death		
,			533 Welbrook Road					Essex			- I-	D : (B)		imore Cou		
	Funeral Director		5. Social Security Number 216–96–8558	6. Sex		(In yrs. la 44	st birthday) Yrs.	If Under Months	Days	Hours		03/04/			nplace (State or n Canada untry)	
9	any		Usual Residence of Decedent  10a. State 10b. County	,	11	0c. City,	Town or Locati				10d. Inside City Limits					
K	<b>B</b>	-	MD Ba	timore	1		Essex						1 Yes 2 X N			
30	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 533 Welbrook	Road	<b> </b>			10f. Zip (	ode 2122	1		10	10g. Citizen of What Country? USA			
	ath with items 23:	Funeral	11. Marital Status  1 Never Married 2 X	Married Ar	as Decedent E	_		s Deceden es, specify				fy Yes or No- an, etc.)	14.	Race - Ameri White, etc.	can Indian, Black,	
	s after de ral", or	by Fu		ivorced If Yes, C	ive Year	No	1	Yes 2			- 4 - 5			ecify: whi		
	16 n 72 hour ian "natu iest Exau	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12 12	lege (1-4 or 5-			rs Usual Cost of work rechn:	ing life. [	DO NOT u				of Business/I	Services		
	5-0036 lled within 7 Hygiene. I other than	Comp	17. Father's Name (First, Middl					ecini		3.Mother's	,	rst, Middle, M	/laiden Su		Services	
	2121 ould be fil Mental I marked c event,	To Be	Andrew Ma  19a. Informant's Name/Relation	agill Iship (Type, Pri	nt )		19b. Mailing	Address	(Street			Duffe	at emergation	or Town, State	, Zip Code)	
	MD d 2 shoulth and m 27 is aumatic		Sandra Zack	/ Wife	-	<del></del>	533 V	Velbr	ook :	Road,	Ess	ex, M	212	21		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meatlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 X Cremati  4 Donation 5 Other	Specify:		Fin	Place of Dispos crematory or oth IAL JOUI	ner place) ney	Crem	. 1	11/24	/2009	Wo	ation - City or odbine,		
	Balt permit. Departi Import		21. Signature of Funeral Service 23a. Part I. Enter the disease,	/ L	77	A	1 <b>11</b>   22. N	Mary PO	ddress Tan Box	d C1	cema	tion altim	Serv	rices MD 2	1203	
	Physician /Medical		23a. Part I. Enter the disease, failure. List only one caus	e on each line.										or heart	Between Unset and	
2	xaminer		Immediate Cause (Final diseas or condition resulting in death)		ced dru		rntany]	., c1	onaz	eram)	int	oxicat	ion		Death	
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/M	iF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 4	If yes, outcom Live birth Pregnant at t Unknown		2 Fe	tal death her (Spec	3 [ ify)	Ectopic	pregnancy	/		Date of deliver	y Day Year	
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	ls, P quires t en sign			<u>-</u> -	·						{	1 Yes			bably 4 Unknown utopsy findings available	
	of Vital Records, ng Physician: The law requir Mer this certificate has been s meral director, page 2 should I	Completed		<del> </del>		<del></del>	. <u>.</u>					autop	sy rmed?		completion of cause of	
	Of Vital Recing Physician: The I	Be Cc	25. Was case referred to medic examiner?					2		of Death (	Check onl					
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1	Sion of Attenting Ph death.	ertification:		estigation N	a. Date of Injur (Month, Day,Ye OUND: ov 20, 2009		FOUND: 1939 hrs		1 Y	es 2 X	No u	nk				
1	Division pital or Attendions after death.	Certific	3 Suicide 6 X Co	uld not be 28		esid	ence	et, factory,	office bu	uilding, etc	28	or Town, S	Street and State) 53 SSEX,	Number of Ri 3 We 1b1 MD	ural Route Number, City	
,	Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To	the best of my basis of exam	knowled	ge, death occu nd/or investiga	rred at the tion, in my	time, dat opinion,	te and place death occ	ce, and du curred at th	e to the caus ne time, date	se(s) and r and place	manner as state, and due to the	ted. ne cause(s)	
	F 3 F 8	Me	29b. Signature and title of certi		1		1	29c	O.C.N	number 1.E.				,	onth, Day, Year)	
		3 3	30. Name and address of personal Assistant Medica				1 23a) et, Baltimore	MD 2	1201	F- 4				ember 2	1, 2009	
	<u> </u>	tate	31. Date filed (Month, Day, Yea	r)	32. Registrar	's Signatu		S, WID Z		Zab	1ull.	ah Ali	, MD			
	Regis	trar	NOV 2	4 2009	Gener	<i>u</i> /	a. 490	elec.	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2009 May Marsiglia 8:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3910 Sharp Road Glenwood Howard 6. Sex **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Davs 1 M 2 2 Months Hours Min. May 6, 1924 Director Maryland 216-16-9133 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Maryland Howard G1enwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3910 Sharp Road 21738 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates 3 KWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nicholas Basciano Margaret Ranzino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Marsiglia, Sr. Glenwood, Maryland 21738 3719 Appleby Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lorrain Park Cemetery 11-25-2009 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Hones, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 Part 1. Enter the lace to e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOUARDTELL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AURTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Year Day Pregnant at time of death as been signed by the 2 should be detached 9 Unknown □ 1Jnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL MARILLATTON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSON 24a, Was an has autopsy performed? Yes 2 No page this certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **K**Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🌉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

3416 CLAMPINDES COURT.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

um

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1050 November 14 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner rapyland General saltimore 8. Date of Birth (Month/Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2X1F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltmore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA Hvenue Willow 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1☐ Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be 2 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Hvenue Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other 20c. Location 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses 110155 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Caured Immunodeficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No the be detached 9 Unknown 9 Unknown þ signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2 No this certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 3 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title qf certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

A. AHMEI 31. Date filed (Month, Day, Year)

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MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2 32. Registrar's Signature

N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5perFH G898 12/2/09 WS State of Maryland Department of Health and Mental Hygiene 37598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 21, 2009 Samuel Nelson McNutt Jr. 5:45 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Social Security Number 219–50–9980 218–50–9980 6. Sex 1 X M 2 ☐ F Birthplace (State or Foreign Country) Oct. 8, 59 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 512 Plumtree Road 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 12 Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Nelson McNutt Mary Trellis Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn McNutt / Wife 512 Plumtree Road, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Services Corp.11/25/09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHAL Due to (or as a consequence of): NIKICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MYOCARDIAL 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 D No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical **Examiner** Vital Records, November within 2

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

Examine

Physician/Medical

Completed

Be

Certification: To

Medical

29a. Certifier (Check only

**Funeral** 

**Director** 

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, Its. Medical Examinat must be notified at

Important: If item 27 Is any injury or attended

Baltimore,

STGDCCCCM

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of person who com PATRICEA GURN, MD

pleted cause of peath (Item 23a) (Type, Print) 3. Registrar's Signature

MEDICAL CENTER

Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BELAIR MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ :23AM aven ber 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lenb Ametrun <del>caltimore Washing ton Medical</del> rnie 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. (Month, Day, Ye **Funeral** 1 □ M 2 🗵 F Country) Director 213-64-0651 61 Yrs. Dec MD Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 뉽 Director 28a-f Examiner must be notified 1 Yes 2 No Maryland Anne Arundel Glen Burnie 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7622 Francis Road 21060 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Support State of Maryland 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Conroy Gloria Bolander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7852 Oyster Shell Court, Baltimore, MD 21226 Sally Bossert (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Date 30 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 2009 4 Donation 5 Other (Specify) Crownsville, MAryland 21. Signati uneral 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 to that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AC. 0085 M Sequentially list conditions if any, making to immediate Examine cause. Enter Underlying burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other. ပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursin Home 5 Residence 6 Other S ecity within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 03

DHMH 17 Rev 7/2009

State Registrar MICHICAL

CENITA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

IM OILE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			For State Registrar	State of Maryla	and / Dep <i>Ce</i>	ertificate of E	lealth and N Death	/lental Hyg 	iene 20	09	37600
	Physicia		Decedent's Name (First, Middle, Last     Robert Anthony	Meara, Sr.				2. Date of Deat Month Novembe		2009	3. Time of Death 10:45 A.M
	Medic Examin		4a. Facility Name (if not institution, give s				Location of Death		4c. County	of Death	201 13 11.
	Funeral		4615 Keswick Road 5. Social Security Number 6. Se	5 m	s. last birthday)	If Under 1 Year Months Days	imore If Under 24 Hrs. Hours Min.	8. Date of Birth	N/.	g. Birtho	lace (State or Foreign
	Director		216-12-0634 12 Usual Residence of Decedent	JM 2 □ F   88	} Yrs.	World Suys	Tiours William	July 30	, 1921	Mar	ÿland_
	aryland a-f sho fied at	ctor	10a. State 10b. County		City, Town or L					10	0d. Inside City Limits 1 X Yes 2 □ No
	the Ma or 28a e notif	Funeral Director	Maryland N/A  10e. Street and Number		<u>Baltimo</u>	10f. Zip Code		1	I0g. Citizen of W	/hat Count	
	th with ms 23a must b	ınera	4615 Keswick Roa		uo Iro		.210			S.A.	
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 🏋 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates. WW	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	n, Mexican, Puerto	Rican, etc.)	Black	14. Race - American Indian, Black, White, etc.  Specify: White		
215-0036	72 hour "natu ledical	Completed	15. Decedent's Ed (Specify only highest grad		(Give	edent's Usual Occup	ation during most of work	ing	16b. Kind of Bu	siness Ind	ustry
	within giene. er tha! t, the N		Elementary/Seconday (0-12)	College (1-4 or 5+) 4 years		DO NOT use retired) Chemist/Journalist Baltimore Sun Pa					
Maryland 21	should be filed with h and Mental Hygier 7 is marked other t traumatic event, th	To Be	17. Father's Name (First, Middle, Last)  Daniel Justin Me	ara			18. Mother's Nam	e (First, Middle, N	laiden Surname, Zepp	}	
lary	should and Me is marl aumati		19a. Informant's Name/Relationship (Type		19b. Mail	ing Address (Street a				ate, Zip C	ode)
Ġ,	of Health of Health of Item 27		Frances Amy Macko 20a. Method of Disposition	20b		Briarwoo	1	Baltimore	e, Mary]		
altimore,	Page 1 ment of ant; If it ury or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	ematory or other place unt Crema	e)	24-09		•	Maryland
Balt	permit. Page 1 Department of Important; If i any injury or once.		21. Signature of Funeral Service License	rasse	2	Name and Address Mitchell- 6500 Yor	wiedefeld k Road F	l Funeral Baltimore	l Home, e. Marvl	Inc.	21212
			23a. Part 1. Shter the disease, or comp shock, or heart failure. List only on	ications that caused the de e cause on each line.							Approximate Interval Between Onset and Death
	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or say onse	con c	la l	njaro	llor			Oriset and Death
	Examiner	er	Sequentially list conditions, if any, leaging to immediate	o.  Due to (or as a conse	Surrence of		v			+	
þ.	uted nd ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	C.	squerioe oi).						
_	cate be executed physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a conse	equence of):						
09/g	tificate ng phys as the		IF FEMALE:	u							
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	☐ Ectopic pregnand ☐ Other (specify)	у		23d. Date Mor	e of delive	ry Day Year
л. О	s that the gned by be deta	ρ	Part II. Other significant conditions co	ntributing to death but not i	resulting in the	underlying cause giv	en in Part I.				e cause of death?
ords	require been si should	leted						1 ∐ Ye			ably 4 Unknown
Ž Ž	The law ate has page 2	Completed						autops perform 1 \(\sum \) Yes	med? d	rior to con eath? Yes	npletion of cause of 2  No
Ital	stcian: certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:		Othe	ace of Death (Chec	k o <i>nly one)</i> ome 5 Reside	م ا	(0 (1)	
Division of Vital Records,	ending Physeth.  or After this  te funeral of	Certificate: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Injury work	/ at	28d. Describe ho			
INIS	al or Atte s after de l Directe c in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (Str City or Town		r or Rural I	Route Number,
_	the Hospit in 24 hour the Funera	Medical	(Check 2 Medical Examir only one) 3 Certifying Nurse	cian: To the best of my knower: On the basis of examina Practioner: To the best of	tion and/or inve	stigation, in my opinio	on, death occurred a	t the time, date an	d place, and due	to the caus	se(s) and manner stated.
			29b. Signature and title of certifier	Bowi	emo	1 -	0649		9d. Date signed	3/0	9
	þ		JOHN W. BOWIE,		em 23a) (Type, <b>N.</b> Ch	Print) IARLES 3	ST. #490	Z TOU	uson, n	1ARYL	AND 21204
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2 4 2009	32. Registrar's Sig	nature	0					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BACTIMORE REHABILITATION EXTENT None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. August 12, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** X X M 2 □ F Months 218-12-4261 Mary Tand 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eventher anul be neithed any injury or other traumatic event, I'm Medical Eventher anul be neithed at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1854 Circle Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2XXNo Completed by If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 XXDivorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pilot Airline 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Bernard MacDermott Sr Ethel Mevers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1854 Circle Road Towson, Maryland 21204 R.B. Diffenderffer Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemeterly Jan 27,2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the di case, or co shock, or heart fa ure. List of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 ☐ Yes 2(X) No

Year

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mar per verb	yland Depa 9897, 117 Cert	24709ahb tificate of L	lealth and Death	Mental Hygi Re 2. Date of Death		37602			
Physicia /Medic Examine	al	4a. Facility Name (If not institution, give str	eet and number)	M	noR 4b. City, Town, or	Location of Deat	Novembe					
Funeral		The Johns Hopkins Hos 5. Social Security Number 6. Sex	7. Age (i	In yrs. last birthday)	Baltimore	If Under 24 Hrs	8. Date of Birth	(oarl 9	Birthplace (State or Foreign Country)			
Director		Usual Residence of Decedent	M 2 🗆 F	36 Yrs.	Months Days	Hours Min.	(Month, Day, ) Oct 24	1973	Maryland			
e Maryland Ba-f show	Director	MD 10b. County	1	oc. City, Town or Loc Balt	cation				10d. Inside City Limits 1   Yes 2 □ No			
with the	Dir	10e. Street and Number 2524 E. Chase Stre	o.+		10f. Zip-Code	1.0	10	g. Citizen of Wha	at Country?			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral		2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2♥ No		Vas Decedent of H	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc.			
r2 hours a natural", o ical Exam	sted by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade		16a. Deced	☐ Yes 2X No	Specify: ation		Specify: black  . Kind of Business/Industry				
ed within 7 /giene. er than "n , the Medi	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		kind of work done during most of working OO NOT use retired)  driver transportation							
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	me (First, Middle, M	faiden Surname)	unk			
D = D =		19a. Informant's Name/Relationship (Type  The Johns Hopkins	,	600	N. Wolfe		Baltimore	MD 2	1287			
Page nent o int: If		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 ★ Other (Specify)	in state		natory or other plac			Oc. Location - Cit				
permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee Ronald S W	de	Ba	ltimore,	MD 212						
Physician	3.	23a. Pa 1. Enter the Lease Complic shock or heart filiure. I st only one Immediate Cau Final disease or condition a.	cause on each line.	is death. Do not ente	er the mode of dyir	ig, such as cardia	ic or respiratory arre	st,	Approximate Interval Between Onset and Death			
Medical pe executed purious and purial-transit purial-transit	I Examiner											
death certificate a attending phys ed for use as the	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of 1  Live birth 2 4  Pregnant at tin 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)  23d. Date of delivery Month Day Year							
uires that the signed by ald be detact	d by Phy	Part II. Other significant conditions cont Acquired mmune	ributing to death but	ven in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown							
The law req	Completed		1 (	J 0			24a. Was an autopsy perform 1  Yes 2	pri	ere autopsy findings available or to completion of cause of ath? Yes 2 □ No			
sician: certific	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient	2 ER/Outpatient	t 3 DOA Othe	ar.	ath <i>(Check only one)</i>		(Specify)			
ding Physth. After this funeral d	tion: To	27. Manner → Death  1 ☐ Natural  2 ☐ Accident investigation	28b. Time of Injury	28c. Injur Work	y at	· · · · · · · · · · · · · · · · · · ·	e 5 Residence 6 Other (Specify)  Bd. Describe how injury occurred					
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	reet, factory, office  281. Location (Street and Number or Rural Route Number, City or Town, State)									
ne Hospita n 24 hours ne Funera pletely fille	edical (	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the To the Complex	Me	29b. Signature and title of conflict	Hewin	-	29c. License number  RESCOO  VOVEMBER 11, 2009							
		30. Name and address of person who cou	vine		Print)	600	North Wolf	e St, Balt	imore, MD, 21287			
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature								

		Ī	For State Registrar		State of M	arylan	d / Depa <i>Cer</i>	artment of F tificate of L	Health and M Death	Mental Hy	giene Reg. No. 200	9 37603	
ı	Physicia Medio		1. Decedent's Name Roman	s Name (First, Middle, Last) oman Myslinsk						2. Date of Dea Month NOV •	ath 19, Day 2009 ear	3. Time of Death	
	Examin		4a. Facility Name (if 7309		street and number) VC •			4b. City, Town, or Baltimo	Location of Death		4c. County of De n7a	ath	
	Funeral Director		5. Social Security Nu 212-20-87	719 1	x 7. Ag M 2 □ F	e (In yrs. la 84	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	9. E y, Year) r 17.1924	Sirthplace (State or Foreign Country) Virginia	
-	and show	ō	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	cation			,	10d. Inside City Limits	
	Maryli 28a-f otifiec	irect	Md.	N/A				Baltimo	re			1 ¥ Yes 2 □ No	
	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	Funeral Director	10e. Street and Num 7309 F	ait Ave.				10f. Zip Code	21224		10g. Citizen of What (USA	Country?	
9036		ρ	11. Marital Status 1 □ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		ŀ	Vas Decedent of Hi FYes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W		
15-(	vithin 72 hour jiene. er than "natu the Medical	Completed			st grade completed)		(Give I	lent's Usual Occupa kind of work done of O NOT use retired)	's Usual Occupation of work done during most of working		16b. Kind of Busines	s Industry	
212	within 7; /giene. <b>ner than</b> <b>t, the M</b>		Elementary/Seconday (0-12) College (1-4 o			Printer				Printing			
land	12 should be filed within alth and Mental Hygiene. 27 is marked other than r traumatic event, the M	To Be	17. Father's Name (F Frank M	First, Middle, Last) Myslinski						ne (First, Middle, . na Secko:	dle, Maiden Surname) KOTA		
lary	should and M is mar aumat		19a. Informant's Na		-			g Address (Street a	and Number or Run	al Route Number	lumber, City or Town, State, Zip Code)		
e, R	and 2 Health tem 27		Karen He		Daughte:	-T		9 Fait Av	· · · · · ·		id. 21224 20c. Location - City (	or Town State	
Baltimore, Maryland 21215-0036	Page 1 nent of ant: If it		1 😡 Burial 2 [		Removal from State	C	emetery, cren	natory or other place Cemetery	e) Nover		Dundalk,		
Balt	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Fur	neral Service Licens	Conv	el	Qu 22	Name and Addres	ss of Facility		Dundalk, I	A	
	Physician/ Medical		23a. Fart 1. Enter the disease or complications that caused the death. Durot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)   a.										
	Examiner	er	Sequentially list con	nditions,	Due to (or as a consequence of):  b. ———————————————————————————————————								
V	executed an and ial-transit	xamir	cause. Enter Under Cause (Disease or i that initiated events	lying linjury	C	Due to (or as a consequence of):							
ca paragraphic													
68760	ding physe as the		IF FEMALE:		22a Ifusa sutasma	of myomen							
). Box (	or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1  Eive Birth 2 Fetal death 3 Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)								23d. Date of d Month	lelivery Day Year	
ds, P.O.	quires that en signed b	ted by P	Part II. Other signifi	' (	ontributing to death b	1 1	ulting in the u	,	ren in Part I.		tobacco use contribute to the cause of death?  Yes 2 No 3 RProbably 4 Unknown		
Division of Vital Records,	The law re cate has be page 2 shu	Comple	Pulmonary embolism  24a. Was an autopsy performed?  1 Xyes 2   No							prior to rmed? prior to death?			
/ital	rsician s certifi lirector	To Be	25. Was case referre examiner? 1 ☐ Yes 2   ✓		Hospital:	ont 2 🗆	ER/Outpatien	Othe	ace of Death (Chec		lence 6 🗆 Other (Spe		
of	ing Phy vfter this uneral c		27. Manner of Death		28a. Date of inju (Month, Da	iry	28b. Time of injury	28c. Injury work	/ at ?		ow injury occurred	eciry)	
ivisior	or Attend after death Director: A in by the f	Certificate;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At holiding, etc. (Specific Coulding)						Yes 2 No	28f. Location (S City or Town	(Street and Number or Rural Route Number, wn, State)		
۵	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical (	(Check 2	Medical Exami	ner: On the basis of e	xamination	and/or invest	igation, in my opinio	on, death occurred a	t the time, date a		e cause(s) and manner stated.	
2	To the within To the comple		only one) 3 29b. Signature and t		e Practioner: To the	best of my	knowledge, c	29c. License	number		e cause(s) and manner a	oth, Day, Year)	
			30. Name and addre	0. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
			TH	HOMAS	FINU	LCA	NE	ا ا	shing H	opkin	s bay	view	
	Stat Registra	_	31. Date filed (Month	23 2009	32. Registra	ar's Ignat	marke	9		·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, 19b per fh g897 11-24-09 vt. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical NO V HERBERT 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMER MONTGOMERY GENERAL HOSPITAL DLNE 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Hours Min 0572471921 88 Director 218-18-6687 MD Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director MD MONTGOMERY SILVER SPRING 1 Yes 2 No WORLD BLVD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA Funeral 2901 SOUTH LEISURE BLVD-12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【A] No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked offers any injury or other? 1 Never Married 2 Married Completed by Specify: WHITE 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **ATTORNEY** LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REBECCA LOUIS MILLER PLATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number on RED) tell Live City or Town, State, Zip Code) SILVER SPRING, 20906 2901 SOUTH LEISURE BLVD.,#131 IRENE MILLER / WIFE 20a. Method of Disposition
1 ⚠ Berial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State BETH TFILOH CEMETERY 11/23/2009 BALTIMORE, MD 4 Donation 5 Other (Specify) eral Servic Licer 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or compilications that caused the dishock, or heart failure. List only one cause on each line. ah. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIVE HEART Physician/ disease or condition Medical resulting in death) **Examiner** CARDIOMYOPATHY ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine HEMOPTYSIS To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical PNEUMONITIS Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LEFT UPPER EXTREMITY 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ON CHRONIC KIDNEY FAILURE 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D59418 NOVEMBER 22,2009 Baurenmz, mo MONTGOMERY GENERAL HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADEWUNMI, OL MEMISI

State Registrar State of Maryland / Department of Health and Mental Hygiene 2009 37605

			For State Registrar		State of F	viai yiai i		tificate of	Death		eg. No.		370	UJ	
	Physicia	an	1. Decedent's Name (First, Middle, Last)								h Day	Year	3. Time of De		
4	/Medic		ELYA						MAKHLIN NOVEMB  4b. City, Town, or Location of Death			2009 nty of Death	7:55 P	) IVI	
	Examin	er	4a. Facility Name (If not in			er)		PIKESVI		or c		IMORE			
-	MILFORD MANOR NURSING HOME  5. Social Security Number 6. Sex 1 M N 2 F							If Under 1 Year Months Days	If Under 24 Hrs		Birth 9. Birthplace (State or For			oreign	
	Director		220-35-9808	AJM 2LIF	M 2 □ F 84 Yrs.			Months Days Hours 11-			25-1924				
	land ow		Usual Residence of Dece 10a. State 10b.	County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City I	Limits	
	the Maryland 28a-f show	tor	MD N	I/A		BALTIMORE							1 <b>X</b> Yes 2	□No	
	or 28	Director	10e. Street and Number			10f. Zip Code				0g. Citizen o		ntry?			
	s 23a	eral	3 AMLEHT COU	IRT, #1		nt Fuor in II	6 12	21215	Hienanic Origin? (5	Specify Yes or No-	US 14 B	A Race - Americ	can Indian.		
(0	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaninar must be multiled at or other traumatic event, the Medical Evaninar must be multiled at	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2</li></ul>	Married	12. Was Decede Armed Force 1 ☐ Yes 2	No			Hispanic Origin? (S ban, Mexican, Puer	rto Rican, etc.)	В	lack, White,			
036	ral", o	ð	3 ☐ Widowed 4 ☐ D	If Yes, Give Year or Date	Year or Dates:			1 □Yes 2 🕅 No Specify:			Specify: WHITE				
5-0	"natu	letec	15. E (Specify on	ucation de completed)	eted) (Give kir			dent's Usual Occupation kind of work done during most of working OO NOT use retired)			16b. Kind of Business/Industry				
21215-0036	within iene. than	Completed	Elementary/Secondary	College (1-40	College (1-4or 5)			FESSOR			EDUCATION				
DC 2	al Hygi other vent, I	BeC	17. Father's Name (First,	Middle, Last)				<del>-</del>		me (First, Middle,					
Maryland	should be f and Mental I s marked oi umatic eve	5	ISAAK				MAKHL		MARIA			UNKNO			
Mar	12 sho th and 7 Is ma trauma		19a. Informant's Name/F					-	et and Number or F				) Code)		
	t and 2 Health tem 27 I		20a. Method of Disposition		ILE	20b. F		esition (Name of matory or other p	RT, #1C,	Date	20c. Locatio	n - City or To	own, State		
m 0	Pages nent of h ant: If ite ury or of		1 X Burial 2 □ Cre 4 □ Donation 5 □ 6							2-2009 R	EISTER	STOWN	, MD		
Baltimore,	permit. Page Department of important: If any injury or once.		21. Signature of Funeral	Service Licen	<b>9</b> (8)	<i>p</i> , . <u>c</u>	2	2. Name and Add	W CEM. 11-22-2009 REISTERSTOWN, MD  Address of Facility SOL LEVINSON & BROTHERS, INC. ISTERSTOWN ROAD, PIKESVILLE, MD 21208						
	20.5 % 2		100	3	M							LE, M	D 21208 Approximate		
			Interval Bet										Interval Betwee	een eath	
Ì	Physician /Medical		disease or condition resulting in death)		a	as a consec	uence of):	(0)	901				CIVIC	TVC V	
	Examiner		Sequentially list condition		b										
	ed sit	iner	Sequentially list condition if any, leading to immedia cause. Ener Unuellying Cause (Disease or injury that initiated events	ate	Due to (or	Due to (or as a consequence of):									
	and and al-tran	Examiner	that initiated events resulting in death) Last		cDue to (or	Due to (or as a consequence of):									
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99	± 00 α	Medical	IE EEMALE:	-				-				1			
								☐ Ectopic pregna☐ Other (specify)		23d. Date of delivery  Month Day Year					
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ر. ت	s that med b e deta	by Pt								bacco use c	pacco use contribute to the cause of death?				
ğ	equires en sign buld be	led t		107	vac r	1				1 1	es 2 □ No				
Records,	e law require has been sige 2 should b	Completed	24a. Was an autopsy performed death									4b. Were auto prior to co death?	opsy findings av ompletion of cau	vailable use of	
a	iclan: The certificate ector, pag		05.14/	di1					OC Pleas of D	1 ☐ Yes eath (Check only o	2 🗷 No	1 ☐ Yes	2 No		
of Vital	Physician: The rthis certificate h ral director, page	o Be	25. Was case referred to examiner?  1 ☐ Yes 2 ☐ No	medical	Hospital:	patient 2	ER/Outpatie	nt 3 DOA	Other:	Home 5 ☐ Resi		Other (Spec	ify)		
n of	<u>a</u> + <u>a</u>	n:T	27. Manner of Death 1 Natural 5 [	Pending	28a. Date of (Month,	Injury Day, Year)	jury 28b. Time of 28c. Injury at 28d			28d. Describe	28d. Describe how injury occurred				
siol	Attending or death. ector: After by the fune	catic	2 Accident	investigation		M 1 ☐ Yes 2 ☐ No			28f Location (	20th Leasting Charles of Number 2 Part Route Number					
Division	or At after d Direct	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or 7							City or To	(Street and Number or Rural Route Number, own, State)				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	cal C	(Check only 2	Certifying Ph Medical Exar	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	thin 24 the Formplet	Medical	one) 29b. Signature and title of	4	and manne	r stated.		29c Lice	ense number		29d. Date sid	aned (Month	n. Dav. Year)		
	<b>₹</b> ₹ ₹ 8		) KA	The same of the sa	V	us		D	27569 838 G		11/	20/0	9		
			30. Name and adress of	of perso who	completed cause	of death (Ite	m 23a) (Type	, Print)	V71 1	(11 1		01		n ,	
_				1914	in We	H 10	male	1 /	038 0	lene	ree	2 SEA	uw	8	

State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ruth Nichols 06:5 NOVEHBER 21 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a Agnes Balthore HOSPITA 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours 218-52-2126 87 12/30/1921 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Baltimore Catonsville 1 ☐Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21228 719 Maiden Choice Ln. BR329 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Gates Mary Wallis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rdward R. Nichols / Son 3821 Shadow Lane, Virginia Beach, Virginia 23452 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐Donation 5☐Other (Specify) Lakeview Mem. Park 11/24/2009 Sykesville, Maryland e of Funeral Service lescensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 9 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unknown Due to (or a consequence of) Heast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical **Examiner** requires that the death certificate be execute and

Examiner

**Physician** 

Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than '

other traumatic

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau
once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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attending physician has After this

Records,

Division of Vital

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The law

or Attending Physician:

Hospital

24 hours after deatle Funeral Director:

within 2

Physician/Medical filled in by

ģ Completed Be Certification: To 27. Manner of Death

Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

cal

5 Pending investigation

6 Could not be determined

Date of Injury (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier Verrea

P24070

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) NOVEMBER 21 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERMA

SANGITA 31. Date filed (Month, Day, Year)

2 4 2009

900 Caton Ave. Baltimore, MD 21229 82. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nevins Margaret Novembo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore N/A 8. Date of Birth
(Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 🗗 F Months Hours 214-22-8074 **Director** 83 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director MD N/A Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1111 Falls Hill Drive 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc "natural", or Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 2 **XX**0 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. Specify: 3XXWidowed 4 □ Divorced Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Duvall Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Nevins (Son) 1119 Falls Hill Drive Balto. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Durial 2 XX remation 3 Removal from State Atlantic Crematory 11/24/09 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Live 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home,
3631 Falls Road Balto, MD 2121 Inc. Falls Road 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pulmonary Physician/ Chronic Obstructive Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death n signed by the a lid be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been siç ; page 2 should b ertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **N**O မှ 1 🗌 Inpatient 2 🗷 ER/Outpatient 3 🗌 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

Craig Gold DO

1838 Greene Tree Road 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4135

29c. License number

53088

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21208

November 20, 2009

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 1009

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 19, 10:10 PM Mitchell Eugene Nicoll Sr. November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Charlotte Hall St. Mary's Charlotte Hall Veterans Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Min. Maryland Director 5, 1929 217-26-7759 80 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examinar cust be notified at 1 ☐ Yes 2 🛣 No Director Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 201 Glenwood Road 21014 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Soap Manufacturing Factory Worker traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchell E. Nicoll Marion Adeline Fifer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 201 Glenwood Road, Bel Air, Maryland 21014 Maureen Adele Cohen / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Specify 3 Demoval from State Druid Ridge Cemetery 11/23/2009 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. ture of Funeral Se 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the Iseas., or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 2 HEIME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Directo (or as a nonsequence of): Examiner or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESSENTIAL HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ARTERY ORONARY 24a. Was an autopsy performed this certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 1√10 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D67788 11.20.2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO

Registrar

State

LEENA

31. Date filed (Month, Day, Year) NOV 2 4 2009

KODALI

32 Registrar's Signature

29449 Charlotte Hall Rd., Charlotte Hall, MD 21622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year LESTER **OSBAND** 09:20 AM November 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Singi Hospital of Bultimore Baltimore Cit N/ASocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 96 Hours Min 0370671913 NY Director 080-26-1408 Usual Residence of Decedent or 28a-f shov s notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director N/A BALTIMORE 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be USA 21215 5940 CROSS COUNTRY BLVD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Race - America. Black, White, etc. WHITE Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION TEACHER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **OSBAND** permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any injury or other traumatte. **ABRAHAM OSBAND** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5940 CROSS COUNTRY BLVD., BALTIMORE, MD 21215 LAYA HOCHBERG/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 □ Cremation 3 X Removal from State BRITTON ROAD CEMETERY11/20/2009 ROCHESTER, NY 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service licens 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Muocardia days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner arter Coronary yeurs Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a conseq ce of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Hyperlipidemia, coronay 1 Yes 2 No 3 Probably 4 Munknown , parkinson's disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Division of Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0036

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Registrar

DHMH 17 Rev 7/2009

State

29a Certifier (Check

MARTIN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUBIN

SINAL

32. Registrar's Signature

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

HOSPITAL OF BALTIMORE

29d. Date signed (Month, Day, Year)

November 19,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0720\_a<sup>M</sup> **EVORN** ZHINETTA PITTMAN 2009 17 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9815 LANGS RD. APT G BALTIMORE MIDDLE RIVER Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 K X Months Days Hours Min. **Director** 58 217-56-7669 ILLINOIS MAR. Usual Residence of Decedent with the Maryland 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXVo Director MARYLAND MIDDLE RIVER BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9815 LANGS RD. APT G U.S.A. 21220 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 ∐Yes 2**X**XNo Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify: BLACK ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1.5yrs FORKLIFT DRIVER CONTINENTAL CAN permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ို unknown CARRIE S. WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morna Boydner/Daughter 9815 Langs Rd., Apt G., Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) KING MEMORIAL PARK 11-28-09 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. dellim 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Seaso disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X**No 1 ☐ Yes 2 DANG Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

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Division of Vital Records, P.O. Box 68760,

30. Name and address of person, who, completed cause of death (Item 23a) (Type, Print)

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32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 102 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death County of Death Examiner enorthu If Und 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Hours (0 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, II v Medical Examinat must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 W No Specify. ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " ementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Perator is marked other Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 20 a 2 Informant's Name/Relation(ship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Harns Hillian 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of). O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I director, page 2 autopsy 2 | No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only on 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be Other: 4 Nursing 75 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No the Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and due to the course of the Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

3

State Registrar 31. Date filed (Month, Day, Year)
NOV 2 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

Lineur S. Saul

9-08777	Please Type or Print in Black Indelible	Ink. Ensure All Copies Are Lo	egible. 2009 37613
ivica Poole	State of Maryland / Department of Certificate of Ce		2009 3701 Reg. No.
Physician Medical Examine		2. Date of Di Month Novemb	
	4a. Facility Name (if not instilution, give street and number) 824 W. North Avenue #C	4b. City, Town, or Location of Death  Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Months Days Hours Min.	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Wary and
nd show any ce.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc  M D D D D D D D D D D D D D D D D D D		10d. Inside City Limits 1 Ves 2 No
the Maryland a or 28a-f show	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers 27 is marked other than "natural", or items 23a or 28a-f sho mattic event, the Medical Examiner must be notified at once	11. Marital Status 1 Never Married 2 Married Forces? 1 Yes 2 No	Vas Decedent of Hispanic Origin? ( Specify Yes or Yes, specify Cubar, Mexican, Puerto Rican, etc.)	White, etc.
hours after "natural", Examiner	Wildowed 4 Divorced in res, give rear	Yes 2 M No specify:  ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene tt If item 27 is marked other than " other traumatic event, the Medical TO Be Commission	Elementary/Secondary (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)	nbatamist lab Tuchnicla 18. Mother's Name (First, Middl	e, Maiden Surname)
1215. I be filed ental Hy arked of vent, th	E THE POLL SY.	Darlene D.	Imes
ore, MD 21215-003  ges 1 and 2 should be filed within  of Health and Mental Hygiene.  If item 27 is marked other it  ther traumatite event, the Med	anallita Poole-Ikeliani 435	3 Scidell axenue Baltin	Number, City or Town, State, Zip Code)  (ML M) . LLLOO  120c. Location - City or Town, State
altimore, rmit. Pages I at partment of Hee portant: If ite	20a, Metrod of Disposition  20b. Place of Disposition  Burial 2 Cremation 3 Removal from State  Donation 5 Other Specify:		or baltimore, maryland
Baltimo permit. Page Department o Important: injury or oth	21 Signature of Funeral Service Licensee	Name and Address of Facility (hatman- -210 Blaur Road Balt	MD. 21206
Physician //wedical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.  Immediate Cause (Final disease a. Alcohol and narcoti		arrest, shock, or heart Approximate Interval Between Onset and Death
xaminer	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,		
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
	a		
	X UNPENDED  X AMENDED  #1 as noted, 2  IF FEMALE: 23c. If yes, outcome of pregnancy	23a,27,28a-f,permE, g89	8 12/17/09 TT 23d. Date of delivery
Box 68760, e death certificate be the attending physici ed for use as the buri	AMENDED# 1 as noted, 2  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the past 12 months?	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
s, P.O. Boires that the de signed by the	Part II. Other significant conditions contributing to death but not resulting in the	is dilasifying dates given in a series	oid tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
cords law requ has been	Completed	p	Vas an utopsy erformed? es 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?  Yas an utopsy findings available prior to completion of cause of death?  Yas an visual
Vital Recysician: The his certificate director, page	25. Was case referred to medical	26.Place of Death (Check only one)	
of Vit	1 Ves 2 No 1 Inpatient 2 Erroutpair		Residence 6 Other: Scene
on of ending Phath. The funeral	Total   Natural   S   Pending   Fd   11/11/09   Fd   8:	1 Yes 2 X No unk	
Division ital or Attendi urs after death.	Natural 5 Pending Investigation Fd 11/11/09 Fd 8:  Accident Investigation Fd 11/11/09 Fd 8:  Suicide 6 X Could not be determined Could not be determined (Specify) Found residence (Specify)	treet factory office building, etc. 28f, Locati	on (Street and Number or Rural Route Number, City vn. State)824 W. North Ave #C more, MD
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fil	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.  29b. Signature and title of certifier	ocurred at the time, date and place, and due to the igation, in my opinion, death occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
F. ≱ F. 8		29c. License number	29d. Date signed (Month, Day, Year)
O , por	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	November 12, 2009
TOFF	Ling Li, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, MD 21201	
Sta Registra	IAAR BAR AN AT TOTAL BAR AN AN AN AN AN AN AN AN AN AN AN AN AN	R.J	

09-08777

DHMH 17 Rev 1/2001 **OCME 2006** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1) Year 09 Day 17 POSTON WILLIAM 4:56 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CONTER BALTIMORG 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Year) 1 M 2 □ F 164-46-9345 54 01/25/1955 PENNSY/VANIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Ves 2 No BACTIMORG BACTIMORG MAKYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 AMELILA. 3227 CHESTER FIELD AVENUE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2. No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) TOYOTA Elementary/Secondary (0-12) College (1-4or 5+) Auromobile MERRESONTATING 3 SKLOMBARY (12) CUSTOMER SERVICE 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) DORIS SACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BACTIMOKE, MD DIAME POSTON / WIFE CHESTERFIELD AVE, 20b. Place of Disposition (Name of cemetery, crematory or other place) JOSEPH H. GROWN JR. FUNERAL HOME & CREMATURY, 11/19/2009 BACTIMORE, MARYCAND 20a. Method of Disposition 1 ☐ Burial 2. ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOSEPH H. GROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee retuch N. Williams 2140 N. FULTON AVE., BALTIMORE, MARYLAND 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANICER Appendix MIMTH). disease or condition resulting in death) Due to (or as a consequence of): BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETO 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No HYPERTONION 24a. Was an autopsy performed? mu. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28d. Describe how injury occurred

Examiner Physician/Medical

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Completed

Be

Medical Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

28a-f

traumatic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur

**Physician** 

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

and Frans -burialattending physician for use as the burial signed to page 2 should funeral director, nours after death.

neral Director: A
filled in by the fu

Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

or Attending

within 24 hours a Hospital

completely

1 Yes 2 No 27. Manner of Death 5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 □ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 🗌 Homicide 29a. Certifier (Check only one)

2 Accident

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

Kein fra nos

29c. License number P18066

MD 21201

29d. Date signed (Month, Day, Year) 11/17/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , BACTIMORE 221

KETAM PATEL 31. Date filed (Month, Day, Year)

GREENE ST. 32. Registrar's Signature Luck

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Parko

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day No Vember Primo Piccinini 4c. County of Death 200 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Fran Klin cosedale 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) Months 1 XM 2 ☐ F Italy May 26,1931 217-38-4941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo Balto. Nottingham Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4219 Winterode Way 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Dececo Armed Forces? ¹ □Yes 2 □XNo 14. Race - American Indian. 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alfredo Piccinini Maddalena DeAmicis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4219 Winterode Way Nottingham, Md. 21236 Lucia Piccinini Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-21-2009 Parkville, Md. 4□Donation 5 XOther (Specify)Emtombment Parkwood Maus. 21. Signature of Superal Service Lice se 22. Name and Address of Facility Schimunek Funeral Home 21236 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Dec 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Natient 2 I ER/Outpatient 3 I DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

Director

Funeral

\$

Completed

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Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, Item Facilian Examiner must be notified at

permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygid Important: If item 27 is marked other 1 any Injury or other traumatic event, III

burial-trar physician the burial attending p signed by the a

law requires that the death certificate be executed

Hospital or Attending Physician: The

Box 68760

P.O.

Records,

of Vital

Division

page 2 should certificate director, this After this funeral of n 24 hours after death.

e Funeral Director: Af

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ware Drive Baltimore,

29b. Signature and title of certifier

29c. License number D36663 29d. Date signed (Month, Day, Year) 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000 Frank

31. Date filed (Month, Day, State Registrar

4 Homicide

29a. Certifier

Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

completely filled in

within 2. the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37617 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2:15 AM JAMES T PRICE 2009 /Medical ZO 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Age (in yrs. last in Rachinere MD If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 55 Yrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 215-48-2141 1 M 2 □ F Director September 3,1954 Maryland Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at Director Md. Harford BelAir 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 732 Grady Lane by Funeral 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Contracting 12 should be filed w h and Mental Hygiel 7 is marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev James T. Price, Sr Dorothy E. Hatch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie A. Price Spouse 732 Grady Lane BelAir, Md. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview 11-23-2009 | Fallston, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sopricen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> sign d be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy 1 □ Yes 25 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this Medical Certification: To 1X Inpatient 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending To the Hospital or within 24 hours after death.

To the Funeral Director: After a consideral filled in by the fur investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Ö Division of Vital Records,

State Registrar

HO 31. Date filed (Month, Day, Year)

(Check only

29b. Signature and little of certifier

04176435318176

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Green Sheat Balting MD 21201 22 Soutu 32. Registrar's Signature

NOV 24

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

attnew Peters		State of Maryland / Department of 1- For State Certificate of Registrar		Reg. No.	2009 376
Physic ledical Exam		1. Decedent's Name (First, Middle,Last)		Date of Death     Month Day     November 20, 2	3. Time of Death
		MATTHEW PETERSON  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death
		10 North Hilton Street	Baltimore	Date of Pirth (A 444)	DD/YYYY) 9. Birthplace (State or
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 47 Yr	If Under 1 Year   If Under 24Hrs  Months   Days   Hours   Min	_ `	Foreign
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
Maryland 28a-f show d at once.	٥	MD BALTIMOR	E		1 XXYes 2 No
Maryl r 28a-1	Director	10e. Street and Number	10f. Zip Code	10g. Citi	zen of What Country?
with the Maryland ns 23a or 28a-f sho be notified at once.	al D	10 N. HILTON STREET  11. Marital Status  12. Was Decedent Ever in U.S. 13. W	21229 /as Decedent of Hispanic Origin? ( Si	pecify Yes or No-	USA 14. Race - American Indian, Black,
0036 within 72 hours after death with the Maryland giene. Neddical Examiner must be notified at once.	Funeral		Yes, specify Cuban, Mexican, Puerto		White, etc.
after a	۾	3 Widowed 4 Divorced If Yes, Give Year 1 or Dates:	Yes 2 X No specify:		Specify: BLACK
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed		ent's Usual Occupation (Give kind of most of working life. DO NOT use ret		Kind of Business/Industry
036 ithin 7 ne. r than fedica	mple		OW WASHER		CLEANING
The Hyge		17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden	Surname)
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 90 other traumaitic event, the Medica	To Be	MATTHEW R. PETERSON  19a. Informant's Name/Relationship (Type, Print )  19b. Maili	PAULIN ng Address (Street and Number or	E ISAAC Rural Route Number, C	ity or Town, State, Zip Code)
e, MD 1 and 2 sho Health and item 27 is	-			ALTIMORE, M	ID 21229
ore, ME ges 1 and 2 s of Health at If item 27			osition (Name of cemetery, other place)	Date 20c.	Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other t		4 Donation 5 Other Specify: ARBUTUS			LTO., MD
Baltimo permit. Page Department o Important: I			Name and Address of Facility JAI 701–31 LAURENS S		CON & SONS F.H.,INC DRE, MD 21217
Physician		23a/Part I. Enter the disease, or complications that caused the death. Do not enter			
/Medical caminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Methadone intoxicat	ion		Death
1		or condition resulting in death)  Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):			
	Examiner	(Disease or injury that initiated events resulting in death) Last			
ecuted and transit	E E				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edic	XUNPENDED AMENDED 23a,PII,27,26  IF FEMALE: 23c. If yes, outcome of pregnancy	8a-f,perm,E g898	12/30/09 T	Т
876 rtificate ing phy as the	M/ug	23h Was decedent pregnant in the	Fetal death 3 Ectopic pregn		d. Date of delivery Month Day Year
Box 687:  death certifice the attending ped for use as the	Physician/	Description of doth	Other (Specify)		
D. B t the de by the	₾.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
, P.O.	Completed by	Cirrhosis of liver; lung disease		1 Yes 2	No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir as after death.  al Director: After this certificate has been s led in by the finered director, page 2 should the contract of the contra	olete			24a. Was an autopsy	24b. Were autopsy findings availabl prior to completion of cause of
Recol The law icate has	oml			performed?	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?   Hospital: 1   Inpetient   3   ER/Outpatie	26.Place of Death (Check		0 - 4 0 1 0
of Vit ing Physic After this uneral dire	l.	1 ✓ Yes 2 No Indeptied: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Death		ng Home 5 Reside	ence 6 🗸 Other: Scene jury accurred
ion of tending Ph. eath. tor: After ti	Certification:	Pending F1 11/20/00 F1 0	1 Yes 2 X No	unk	
ivisi or Att after de Direct	litica	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Street a	and Number or Rural Route Number, City 0 N • Hilton St MD
Division  Division  Hospital or Attent  24 hours after death  Funeral Director: stely filled in by the	Cer	4 Homicide determined (Specify) nouse		·	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, and ation, in my opinion, death occurred	d due to the cause(s) ar at the time, date and pla	nd manner as stated. ace, and due to the cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		Morganie Ma Voull	O.C.M.E.	No	vember 21, 2009
OXPERT		30. Name and address of person who completed cause of death (Item 23a)  Margarita (Caroll MD) Applicant Madical Evergines 1111	Ponn Street Baltimare MD	21201	· · · · · · · · · · · · · · · · · · ·
\ \ \	tate	Margarita Korell MD. Assistant Medical Examiner 111  31. Date filed (Month, Payl Year) 32. Registrar's Signature	Penn Street, Baltimore, MD	21201	
Regis	tate		1		

**Physician** 

/Medical

Examiner

108	Funeral Director		545-58-	-3558	11	M 2 <del>Q</del> F		0	Yrs. Mor	nths Days	Hours	Min.	Month, Da	ay,
~	p ,		Usual Residence	1			1							
60/61/11	e Marylar ia-f show tified at	Director	10a. State	10b. County	/		10c	. City, Towi	or Location Balt	imore				
-	h th	ie	10e. Street and N	Number					101	. Zip Code				10
	sath witl s 23a o nust be			Frankfo	rd A						1206			
Powel	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Alcal Examiner must be notified at once.	by Funeral		s arried 2☐ Mar d 4√ Divorced		12. Was Dec Armed Fo 1 ∐Yes If Yes, Gi Year or D	orces? 2 No ve	n U.S.	1	ecedent of I specify Cub es 2 No	Hispanic Origi pan, Mexican, Specify:	n? (Spe Puerto F	ecify Yes or No Rican, etc.)	)-
2	115-0 in 72 hc	Completed		15. Deceder pecify only highe	nt's Edu	ie completed)		16a.	Decedent's (Give kind o	Usual Occu of work done	pation during most o	f workin	ng	10
<b>O</b> nzetta	212 24 with /giene er tha	Com	12	econdary (0-12)		College (	1-4or 5+)	As	sembly					
21	Sent a file of the contract of	Be (	17. Father's Nam	ne (First, Middle,	Last)						18. Mother's	Name	(First, Middle,	, Ma
10	ylar	5 E		ess Wi					<u>-</u>		Elnor	a I	Fennel	Ll
4	Baltimore, Maryland 21215-0036  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and mental Hygiene.  Department of them 27 is marked other than "natural", or any Injury or other traumatic event, the Modical Examinance.		19a. Informant's Tracey	Name/Relations  / Willi			ter						≀Route Numb ue-Ba]	
	nore, iges 1 and of He if item or othe		20a. Method of D	Disposition 2 😾 Cremation	3 □ 1	Removal from	State 20	b. Place of cemeter	Disposition y, crematory	(Name of or other pla	ce) NC		ate 2009	20
	Itin it. Pa rtmel rtant njury		4 Donation	n 5 □ Other (S	Specify)	)	E	vans m Ce	erune -mortem	Fair	hapel No		2,2003	F
	Bal perm Depa Impo any It		21. Signature of	Funeral Service	Licens	e CM			22. Nam	e and Addre	ess of Facility		apel a d-Pari	a r
N. N.	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical Examiner	23a. Part1. Ente shock, or Immediate Caus disease or condinesulting in death  Sequentially list of it and it are that initiated ever resulting in death  IF FEMALE: 23b. Was deceded in the past 1 1 1 1 2 5 9 1 Unknow	conditions, immediatelying of injury its its its pregnant 12 months?	{	a	or as a cons	sequence of sequen	of):  1): 3 □ Ectop	oic pregnanc				
	that the the post of the post	/ Ph	Part II. Other sign		ons co	ntributing to de	eath but not	resulting in	the underlying	ng cause giv	en in Part I.		23e. Did to	oba
	ords equires en sign	oleted by	**-										1 🗆 \	<b>r</b> es
	as t	Som		"				W 10	ļa.				24a. Was autop perfo 1 🗆 Yes	osy
;	Clar clar sertif	Be	25. Was case reference examiner?	erred to medical								Death	(Check only o	ne)
,	hysi his c		1 ☐ Yes 2—	3140		lospital: 1 ☐ I	npatient 2	ER/Out	patient 3	DOA Oth	er: 4 🗆 Nursi	ng Hom	ne 5 Hesio	den
	DIVISION OF VITAI RECORDS, To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be d	Medical Certification: To	27. Manner of Der Landaral 2 Accident 3 Suicide 4 Homicide	5 ☐ Pendin investig 6 ☐ Could r	gation not be		h, Day, Year		ime of jury M m, street, fac		yat k? Yes 2⊡No		8d. Describe h  8f. Location (S  City or Tou	Stre
	DIVISIC  To the Hospital or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the it	edical C	29a. Certifier (Check only one)	2 ☐ Medical	ng Phys Exami	sician: To the ner: On the ba and mann	asis of exam	knowledge, nination and	death occur d/or investiga	red at the ti	me, date and ppinion, death	place, a occurre	and due to the ed at the time,	cau
4	To 1 With To t	Σ	29b. Signature an	d title of cortifier		140				29c. Licens	e number 7 ( 7			29d

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. 19, Day 009 Year Frenzetta Powell 8:45 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5918 Frankford Avenue Baltimore Birthplace (State or Foreign Country) 19,1939 Oklahoma 10d. Inside City Limits 1 Yes 2 □ No g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: Black 6b. Kind of Business/Industry HP aiden Surname) City or Town, State, Zip Code) 21206 imore,Maryland Oc. Location - City or Town, State Torest Hill, Maryland nd Cremation Services Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ce 6 ☐ Other (Specify) injury occurred et and Number or Rural Route Number, State) use(s) and manner as stated. re and place, and due to the cause(s) gned (Morth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) ellelid, Ealtwore, Me 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

		1 - State of Maryland / Department of He Registrar Certificate of De			71111	9 37620
Physicia		1. Decedent's Name (First, Middle, Last)  Carol Sue Palmer		2. Date of Dear	th	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Gilchrist Center Towson	ocation of Death	Tovaller	4c. County of Dea	ath
Funeral Director	ľ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	more rthplace (State or Foreign
	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		June 29,		sachusetts
Marylar 28a-f sl notified	irecto	MD Baltimore Parkville				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
h with the rs 23a or nust be r	Funeral Director	10e. Street and Number 2809 Chesley Avenue 10f. Zip Code 21234			10g. Citizen of What C	ountry?
0 2.5	by	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates.  13. Was Decedent of Hisparity (1.5 or 1.5 or	Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
Maryland 21215-0036 2 should be filed within 72 hours affer th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	• Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  12  16a. Decedent's Usual Occupatio (Give kind of work done durin life. DO NOT use retired)  Executive Secondary  15. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)  Executive Secondary  16a. Decedent's Usual Occupation	ng most of working	g	16b. Kind of Business Armoo Ste	
Maryland 2 should be filed h and Mental Hy 7 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Anthony DeMeo	Suzann			
e, Mar and 2 shou Health and em 27 is n ther traum		19a. Informant's Name/Relationship (Type, Print)  George Palmer/ Husband  2809 Chesley F	Number or Rural I	Route Number, Parkvil	City or Town, State, Zi	p Code) 3 <b>4</b>
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of Everative) crematory or other place)  Chapel - Bel Air	11/25	109	20c. Location - City or Forest Hill	, MD
Bal permi Depar Impor any ir		21. Signature of Funeral Service Licensee Evans Funeral 8800 Harford	I Rd. P	el&Orer arkville.	mation Servi	.ces
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.  Immediate Cause (Final lists or condition resulting in death)  a	uch as cardiac or I	respiratory arres	st,	Approximate Interval Between Onset and Death
executed an and rial-transit	Examiner	Sequentially list conditions, if a y, leading to him rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence or):  Due to (or as a consequence of):				
ficate be g physici as the bu	Nedical	d				
Invision of vital records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ Ho o g ☐ Unknown  23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ g ☐ Unknown			23d. Date of de Month	ivery Day Year
dS, P.O quires that the signed by ould be detail		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.		acco use contribute to	the cause of death?
VITAI KECOFIAS, ysician: The law requires is certificate has been sig	Completed by			24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
hysician his certif	20	Hospital:  1	of Death (Check or	.,,	nce 6 X Other (Spec	HOSPICE
al or Attending Pl s after death. Il Director: After the d in by the funera	Cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time of injury at work?  1 Yes			v injury occurred	
tal or Atter safter de al Directo		3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
the Hospi hin 24 hou the Funer	Med	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time	eath occurred at the	e time date and	place and due to the	ougo(a) and manner stated
5 iiw 6 ⊗		29b. Signature and title of certifier  29c. License num  D 643		290 <b>N</b>	d. Date signed (Month	, Day, Year) 220, 2009
20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DANIEUE DOBERMAN, MD 6701 N CHARLES ST,  31. Date filed (Month, Day, Year)  32. Refristrar's Signature	8UR-	4105 E	BALTMORE	E,MD 21204
State Registrar	•	31. Date filed (Month, Day, Year) NOV 2 4 2009 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Otate of Mary		Certificate of			ene	
	Physic /Medi		1. Decedent's Name (First, Middle, Las	st) Oralı J. Pitt				Date of Death     Month	2009 Day Year r 19, 2009	33im/ofocati 10:10 AM
· A	Exami		4a. Facility Name (If not institution, giv 12800 Bridlepat	,			or Location of Death	110 V CHROSS	4c. County of Death Baltimore	
	Funeral Director		213-00-3700	Sex 7. Age (In	n yrs. last birtho 59 Yr	Months   Dave		8. Date of Birth (Month, Day, 12/25/19	year) 9. Birthp Cour Balt.	place (State or Foreign htry) Maryland
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltino		c. City, Town o	r Location Sterstown				0d. Inside City Limits 1 □Yes ŽŽNo
	h with the 23a or 28a	al Director	10e. Street and Number 12800 Bridle	epath Road		10f. Zip Code 2113	36	100	citizen of What Cour Inited Stat Of America	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exprining must be notified at once.	by Funeral	11. Marital Status  1:□ENever Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of I If Yes, specify Cub 1 □Yes 2 ☑ No			14. Race - Americ Black, White, of Specify:	an Indian,
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natur h. A. clost	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	11	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire DOC TOT	pation during most of workind)	ng	Bb. Kind of Business/Inc	
yland 2	ould be filed Mental Hyg arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) Herman V. Pi		,	300 001	18. Mother's Name Regin		iden Surname)	
e, Mar	and 2 sho Health and Im 27 is m her traum		19a. Informant's Name/Relationship (1 Vincent C. Pitt/	brother	37	725 East Ba	iltimore S	d Route Number, C treet Ba	City or Town, State, Zip	code) 21224 lary land
Itimore	nit. Pages 1 artment of H ortant; If ite Injury or ot		20a. Method of Disposition  ** Burial 2 Cremation 3 4 Donation 5 Other (Specify	nemoval from State	Holy Re	isposition (Name of crematory or other placedeemer Center Center)	25, 2	ber 009 Ba	c. Location - City or To	aryland
Ba	perm Depa Impo any I		21. Signature of Funeral Service Licen:	L/a.	i	2325	York Road	Timoniu	un, Marylan	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	Mult.	enter the mode of dylr		r respiratory arres	1	Approximate Interval Between Onset and Death 282 (274)
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	b	nsequence of):					
68760,	ficate be executed physician and s the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a cond.	nsequence of):					
.O. Box (	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ i 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of delive Month	ry Day Year
ords, P.	w requires that the or been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but not	t resulting in the	e underlying cause giv	en in Part I.	1	co use contribute to the	e cause of death?
		Completed						24a. Was an autopsy performed 1 Yes 2	prior to con	osy findings available inpletion of cause of 2 No
	r this certific raf director,	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1 ☐ Inpatient 2	2 □ ER/Outpa	tient 3 DOA Othe	26. Place of Death			
	Viter thi	on: T	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time	e of 28c. Injur	y at 2	8d. Describe how	e 6 ☐ Other (Specify injury occurred	)
Division of	within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, pecify)		Yes 2 □No 2	8f. Location (Stree City or Town, S	t and Number or Rural state)	Route Number,
he Hoenit	nin 24 hour the Funera	Medical O	29a. Certifier (Check only one)	vsician: To the best of my iner: On the basis of exan and manner stated.	knowledge, de mination and/or	eath occurred at the tir r investigation, in my o	me, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
ا ا			29b. Signature and title of certifier	Dier	4	29c. License	o 3886		Date signed (Month, D	1ay, Year) 2009
	4		30. Name and address of person who co	mpleted cause of death (	(Item 23a) (T	Suite 3	os hut	temil	(e, Mg	21036
	Stat Registra		31. Date filed (Month, Day, Year)	2. Registrar's Si		ake			1	

			1 - For State end Maryland / Dep	artment of Health and N rtificate of Death		ene 2009 37622
	Physic		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medi Exami			4b. City, Town, or Location of Death	/(	4c. County of Death
44.0		и	Tate Hospice House	Linthicum Heig		Anne Arundel
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 F  79  Vrs. last birthday)  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 21	9. Birthplace (State or Foreign Country)  1930  Italy
	yland how at		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	he Mar 18a-fs otified	ecto	Maryland NA Baltimon			1x Yes 2 □ No
	with the sa or 2	Ë	10e. Street and Number 6729 Youngstown Avenue	10f. Zip Code 21224	10g	Citizen of What Country?
	ems 2	Inera	11. Marital Status	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1 □Yes 2X No Specify:	Hican, etc.)	Black, White, etc.  Specify: White
5-00	2 hour	ted	3 X Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/Industry
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give life.	kind of work done during most of workin DO NOT use retired)	ng	,
d 2	filed v Hygie other i	Be Co	12 NA Assemb	oly Line	(First, Middle, Mai	artin Marietta
Maryland	Menta Menta arked atic ev	To B	Vincent Piccinini	Anna		Unknown
Mar	d 2 sho th and 7 is m traum			ng Address (Street and Number or Rura		
ē,	s 1 and f Heal ftem 2 other			Barnwood Court Se		ryland 21144  c. Location - City or Town, State
<u>ino</u>	Page: nent o ant: If ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11 Signature of Flower Station Line Tombment  21 Signature of Flower Station Line Tombment	sition (Name of natory or other place) Valley Cardens 25,2	ember	monium, Maryland
Baltimore,	permit. Departimont. any Inj		21. Signature of Funeral Service License 22	Name and Address of Facility Dahrowski/Chojna		ral Homes P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	<u>005 Dundalk Ave. I</u>	Baltimore	Marvland 21224
	Physician		shock/or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	AnTENY DISE		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	10110		
		ē	Sequentially list conditions, if any, leading to immediate b.			
L	ecuted nd transit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
<b>№0928</b>	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):			
9	tificate ig phys as the	ledical	d			
Box	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	A December of treats	Ectopic pregnancy		23d. Date of delivery  Month Day Year
д. О	t the deby the	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		World Day real
_	requires that the	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		co use contribute to the cause of death?
Records,	law requas been 2 should	leted			1 ☐ Yes	
	The ate h page	Completed			24a. Was an autopsy performed	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☐ (Check only one)	No 1 □Yes 2 □No
ö	Phys this al di	5	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  27. Manger of Death 28a. Date of Injury 26b. Time of		ne 5 Residence 8d. Describe how in	e 6 Other (Specify)
NO N	ending sath. or: Aft he fun	atio	1  Natural 5  Pending (Month, Day, Year) Injury 2  Accident investigation	28c. Injury at Work?  M 1 □ Yes 2 □ No		ijury decumen
DIVISION	l or Att after de Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the basis of my knowledge, death examiner: On the basis of examination and/or investment of the complete of the comp	occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Mec	and manner stated.  29b. Signature and title of ceptifier	29c. License number	29d.	Date signed (Month, Day, Year)
		1	MITTER DE LIVER	1 214	38 1	1 ovember 23, 2009
	20	-	30. Name and address of person was complained cause of death (Item 23a) (Type, F	DEYENSE A	6 HWAy	ANNAU MO21401
	Stat Registra	-	31. Date filed (Month, Day, Year) NOV 2 4 2009 32. Registrar's Signature	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# @ B, PERFH, G998, 12/1/09 WS

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

1- State of Maryland / Department of Death

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year **Physician** Walter 23:10 veen Vevember 2009 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 4-11-7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 1 XM 2 □ F Director 213-28-9088 1933 MD Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 XYes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 1307 N. Montford Avenue 21213 SA Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

✓ Ves 2 □ No H As, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 X Never Married 2 - Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: \$ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5h)/a Elementary/Secondary (0-12) Union Memorial 7th grade Housekeeping Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Queen Maggie Sommers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shitley Foster-Friend Shirley 1307 N. Montford Avenue Balto, MD21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3Ŏ Garrison Forest 11-<del>13</del>-09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Dla en 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ancreal /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 **N**o 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred s after dean. \*al Director: After \*v the fi 5 Pending 2 Accident investigation 1 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 24 hours 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) an A RES-000 November 18 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vandana alagisi 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

37. Registrar's Signature

		1	1 - For Amend Item Registrar	23aPtI,25 per	me, g89	7,11/24/ rtificate of	<b>09dhb</b> Death		Reg. No?	009	37624
ı	Physici	an	Donna Lynne	st) Regester				2. Date of De Month	Day		3. Time of Death
· we	/Medic	al	4a. Facility Name (If not institution, given			4b. City. Town, o	r Location of Death	10_	2 G	2009 County of Death	20.28
1	Examir	er	FRANKLIN SQUA		Center		edale			Baltim	ore
	Funeral		Social Security Number     6.	Sex 7. Age (In yrs.	last birthday)			8. Date of Bi (Month, Di May 5 1	rth av, Year)	9. Birthp	place (State or Foreign
	Director		216 94 0031 Usual Residence of Decedent	<sup>1</sup>	Yrs.			May 5 1	966	Baltu	móre,Maryland
	yland now		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	a-fst	ctor	Maryland Baltimore	Ba:	ltimore	County					1 □Yes 2 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code	7			en of What Cour	ıtry?
	eath v	eral	7710 Babikow Road	12. Was Decedent Ever in U	S 13	Was Decedent of h		ecify Yes or N	USA	4. Race - Americ	can Indian.
9800	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar mast be rectified at	þ	1XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2ÆMNo If Yes, Give Year or Dates:		1⊡Yes <b>XX</b> No		Rican, etc.)	.	Black, White, Specify: Wh:	etc. ite
15-(	"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worki	ing	16b. Kin	nd of Business/In	dustry
212	filed within Hygiene.  other than "ent, the Max	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Realto		u)		Remax	(	
Dd 2	il Hyg other	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's Name	e (First, Middle			
ylar	should be fand Mental series was marked our umatic ever	10	Nicholas Donald Rege	ster			Joan L. Wo	od			
Baltimore, Maryland 21215-0036	is 1 and 2 sho of Health and item 27 is mi other traums		19a. Informant's Name/Relationship Ruth Doyle	Type. Print)	1	ng Address (Street babikow Roa	and Number or Run ad Baltimo	ai Route Numb pre ,Maryl			(Code)
more			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci			osition (Name of matory or other place in torver)	october 27	2009		cation - City or To nore ,Mary 1	
Balti	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Lice		Ž.	2. Name and Addre	ess of Facility eral Home In	nc		04000	
The same of the sa	Physician (Madical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	h. Do not en Tem	ter the mode of dyi	Road Baltin ng, such as cardiac Failu	or respiratory a		21230	Approximate Interval Between Onset and Death
7	/Medical Examiner			b. Due to (or as a consequence to (or as a consequence)			ury				
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated was to be considered to the conditions of the con	c. <u>Cardiac</u>		rest		1/	NI EXAMI	NER	
o,	icate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):		A APP	OVED BY MED	(Chr.		
68760,	ate by	Medical		Cardiac Ar	chythm	ia	CERTIFICATION				
O, Box 6	eath certif aftending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1  Live birth 2 Feta 4 Pregnant at time of 9 Unknown	aldeath 3[	☐ Ectopic pregnand ☐ Other (specify) _	Sy .		2	3d. Date of delive	ery Day Year
rds, P.	e law requires that the de has been signed by the le 2 should be detached	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
Division of Vital Records,	The law re ate has bee page 2 sho	Completed	-					24a. Was auto perfi 1 ∐Yes		death?	opsy findings available impletion of cause of
Vita	ician: certific ector,	Be (	25. Was case referred to medical examiner? 1 A Yes 2 110	Magnitule		104	26. Place of Deatl	h (Check only	one)		
of	Phys r this ral dir	Ę.	1 Yes 2 Tho 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie	III 3 DOX		me 5 Res		Other (Speci	<u>(y)</u>
on	Attending Physician: r death. ector: After this certific. by the funeral director, I	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)	Injury	Wor	k?  Yes 2 □ No	200. Describe	now injury	occurred	
Divis	il or Atter after dea Director d in by the	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, factory, office			(Street and wn, State)		al Route Number,
	To the Hospital or Attending Physician: The lywithin 24 Hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the ti	me, date and place, opinion, death occur	and due to the	e cause(s) , date and	and manner as a place, and due to	stated. o the cause(s)
	To the To the Complete	Me	29b. Signature and title of certifier			29c. Licens			29d. Date	e signed (Month,	Day, Year)
	(15)		Har IU	~ MD, MPH		RE	50000		10	126109	
	<u> </u>		30. Name and address of person who DR Heather m  31. Date filed (Month, Day, Year)	anceba a	000	FRANKL	in say	are D	R	Balto M	d 21237
	Sta Registr		NOV 2 4 200	2. Registrar's Signa	par	fee					

Plea J Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 23aPtI,25 per me, 2897,11/24/09dhb

Reg No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH G897, 11 / 30 / 09 WS
State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARE KEHABILI TATION CXTENDED MOKE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min 2 🗆 F Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Never Married 2 ☐ Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Black Specify. Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, Its Madical Est once. "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) barrouss 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Num Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deneene 20c. Location - City or 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition 12/2/09 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation Name and Address of Facility 21. Signatury of Funeral Service Licens Maryland 2121 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) sate has been signed by the a page 2 should be detached to 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No dearh. within 24 hours arter dea.h.

To the Funeral Director A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours aid To the Funeral Di 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier OCH RAVENBUD BALTI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHER A HASHMI MIN 39 (A) CE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Amend 20b Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:30 A M (3mp) 31 900g aron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hookins Boul to solic 1918 3 rdtimor & If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 □ F Days Months Hours Director 307-20-1036 83 Jan.7, 1926 Michigan Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Machael Examiner must be notified a once. MD Carroll 1 ☐ Yes 2 ☑ No Funeral Director Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P. O. Box 1324 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1951-78 1 ☐ Yes 2 K No Specify: Completed by 3 Nidowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Jane Willey Harry Reames ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21158 Carole E.R. Jarrard Daughter 1029 Stone Road; Westminster, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/8/2010 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 1/26/2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, ico mplications that collised the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bight lec works /Medical Due to for a consequence Examiner Foil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 × No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No hours after death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 23, 2009 043 83 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Raltimore 300 VIEW C areenought mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / State Registrar	Certificate of L			liene leg. No. フ ∩ ∩ (	0 07697
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Clarence F. Reinholdt			2. Date of Deat Month	h 200	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	4b City Town o	Location of Death	November	Day Year 19, 2009	6:44 PM
	Examili	er	Gilchrist Hospice	Tows			Baltimor	'e
	Funeral Director		5. Social Security Number 212-26-8951 6. Sex 1 M 2 □ F 7. Age (In yrs. last bin 79	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 28	Year) C	irthplace (State or Foreign ountry) la ryland
	f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow					10d. Inside City Limits
	r 28a- notifie	Direc	MD Ba	10f. Zip Code			10g. Citizen of What C	1 X Yes 2 □ No
	with th s 23a o ust be	<b>Funeral Director</b>	1243 Cedarcroft Road	212.	39°		U.S.A.	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No If Yes, Give ★ Orean Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ▼ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	
Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  12	n. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) Electrician		ing I	16b. Kind of Business Electrico I	•
land 2	d be filed w Jental Hygi arked other itic event, i	To Be	17. Father's Name (First, Middle, Last) Fredrick Reinholdt	THE CEITERS!	18. Mother's Nam	e (First, Middle, N Mæ Clark	,	
, Man	nd 2 should saith and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Sharon Kelmartin/Daughter 8	b. Mailing Address (Street & 618 Richmond A	and Number or Run Venue, Ba	al Route Number, 1 timore,	City or Town, State, Z MD 21234	ip Code)
Baltimore,	Page 1 arment of He tant: If iter		1 X Burial 2 □ Cremation 3 □ Removal from State Du femile 4 □ Donation 5 □ Other (Specify)  Memor	of Disposition (Name of ery, crematery or other place By Valley ial Cardens	e) 11/23/	09	20c. Location - City o	MD
Ball	permit Depart Import any inj once.		21. Signature of Funeral Service Licensee	22. Name and Addres Evans Funer 8800 Harfor	s of Facility a.l. Chapel d. Road. F	& Cremet	ion Service MD 21 2 34	s
	nysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	02-10-E II.	g, such as cardiac (	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. Due to (or as a construence of the construen					YEARS
	red nsit	ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	of):			(i	
ğ O	icate be executed I physician and s the burial-transi	edical Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of the con	of):				
09/89	certificate anding phy use as the		IF FEMALE: 23b. Was decedent program 23c. If yes, outcome of pregnancy					
Rox	ne death co / the attenc ched for us	Physician/N	23b. Was decedent pregnant in the past 12 months? 1	h 3	у		23d. Date of de Month	elivery Day Year
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ed by Pl	Part II. Other significant conditions contributing to death but not resulting  PERIPHERAL PROGRAMS. DISEASE	in the underlying cause giv	ren in Part I.		pacco use contribute t es 2 □ No 3 □ F	o the cause of death? Probably 4 🗆 Unknown
ၓ	sician: The law rec s certificate has bee lirector, page 2 sho	Completed by				24a. Was ar autops perforr	y prior to ned? death?	utopsy findings available completion of cause of
tal	ician: T	Be	25. Was case referred to medical examiner?		ace of Death (Checi			
ot S	g Physical this control of the direction	te: To	27. Manner of Death 28a. Date of injury 28b.	Time of 28c. Injury	4 □ Nursing Ho  at		nce 6 <b>Wher (Spe</b> w injury occurred	city) HUSPICE
lon	ttendin death. tor: Aft the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	_	Yes 2 No			
Division of	To the Hospital or Attending Physiciam: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,		4 Homicide determined 286. Place of Injury - At home, fa building, etc. (Specify)			City or Town		
	tin 24 hosp tin 24 ho the Fune	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, Medical Examiner: On the basis of examination and/o	or investigation, in my opinio	n, death occurred a	the time, date and	d place, and due to the	cause(s) and manner stated.
Þ			29b. Signature and title of certific	29c. License		2 <b>N</b>	9d. Date signed (Mont OVEMBER /	th, Day, Year)
	6+1		30. Name and address of person who completed cause of death (Item 23a) (  DANIEUE DÜBERMAN . MD 6701 M  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Type, Print) V CHANUS S	T, SUITE	4105 B	ALTIMONE	MD 21204
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	marked				·

			1_ State	epartment of Health and Mo Certificate of Death	ental Hygiene 109 37628
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death 3. Time of Death
ш	Physici	an	EDWAND ROBERTSON		Month Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examir	ıer	LUCID WAREN UB; 3900 Lie deux	BOSTO, mo Z	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 14,1921  9. Birthplace (State or Foreign Country) Maryland
	P.		Usual Residence of Decedent		
	n 72 hours after death with the Maryland "naturel", or items 23e or 28e-f show edical Evara et must be redilled at	_	10a. State 10b. County 10c. City, Town	or Location Rosedale	10d. Inside City Limits 1 ☐ Yes 2≸ No
	89-1	by Funeral Director	Maryland Baltimore		
	vith ti	급	10e. Street and Number 4858 Brightleaf Court	10f. Zip Code	10g. Citizen of What Country?
	s 23e	ral		21237	United States
	Hem Hem	nu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 12 Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F</li> </ol>	cify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc.
36	Irs af	by F	3 XWidowed 4 Divorced Year or Dates: WWII	1 ☐ Yes 2 ☐ No Specify:	Specify: White
Ö	2 hou	ted	15. Decedent's Education 16a. [	Decedent's Usual Occupation	16b, Kind of Business/Industry
215	within 72 ene. then "nat	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of workin ife. DO NOT use retired)	g
21	可语言	Completed	10 Years	Electrician	Steel Industry
pu	be filed tal Hygie d other event, I	Be (	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)
Ja		10	Henry L. Robertson, Jr.	Helen	Foltz
Maryland 21215-0036	and and s m				Route Number, City or Town, State, Zip Code)
				615 Rolling Road Be	
ore	ges 1 an t of Heal If item 2 or other	1		crematory or other place)	ate 20c. Location - City or Town, State
Ē	Pa Tr:		`4 □Donation 5 □Other (Specify) Garden	s of Faith Cem. 11/2	1/2009 Baltimore, Maryland
Baltimore,	permit. Pag Depertment Important: any njury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral H	ome of Dundalk, Inc.
=	70 E 9 9		July a fore	7922 Wise Ave. Dune	dalk, Maryland 21222
			23a. Bart1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arrest, Approximate Interval Between Onset and Death
樫	Pnysician	0.4	Immediate Cause (Final disease or condition	MY FALLIRE	6 Hows
	/Medical Examiner		resulting in death)  Due to (or as a consequence of		· · · · · · · · · · · · · · · · · · ·
	LAGITITIE		Sociantially list conditions b. Gorn Pacania	S DUT TO KTIMP	MACRIE & AM
<b>X</b>	ed sit	lne	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	):	
0.	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last  C		
760,	be executed sician and burial-transit	calE		,	$\infty$
687	9 % 9		d		TONINER
χ	The law requires that the death certificate ite has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		CENTIFICATION APPROVED Month Bay Year
Box	atter for u	clan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
P.O.	that the d ed by the detached	ıyslı	1 Yes 2 No 9 Unknown 9 Unknown	O El Ottion (appearly)	CENTIFICATION
	that the		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
sp.	uires n signi lid be	d by	MUETI-INVANCT PENEW NA		1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	w require been sis	Completed	TYPE 2 DIMETES MELL	INS	24a. Was an 24b. Were autopsy findings available
Re	The lay ate has page 2	mc	CONONINY PARTILY DISOSSE		autopsy prior to completion of cause of death?
ta		ပိ	25. Was case referred to medical		1 Yes 2 No
		0	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death	the 5 Residence 6 Other (Specify)
Division of	Physer this eral di	ı. T	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at 2	8d. Describe how injury occurred
ion	ndin ath. r: Aft	atlo	1 □Natural 5 □ Pending (Month, Day Year) In 2 ☑ Accident investigation // 9 2005	ry Work? 1 ☐ Yes 2 ☐ Yo	FORL IN MORSIE LAWAR
Vis	Atte	III C	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)		8f. Location (Street and Number or Rural Route Number, City or Town, State)
	s afte	Certification;	VID LOCA MANES	/	3900 CON KNOW BLIND
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physicien: To the best of my knowledge,	death occurred at the time, date and place, a	nd due to the cause(s) and manner as stated.
	he H in 24 he F plete	Medical	one) and manner stated.	or investigation, in my opinion, death occurre	d at the time, date and place, and due to the cause(s)
	To the within 2.	Σ	29b. Signature and titles certifier	29c. License number	29d. Date signed (Month, Day, Year)
)			Thanks I found mo	mo 0 200	390 11/17/09
	2+1		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	
	2'		30. Name and address of person who completed cause of death (Item 23a) (TC) WALLES (T. JOUESCIS MID & 3900  31. Date filed (Month, Day, Year)  32. Registrar's Signature	LUCIO ICAREN BLUD.	BATO MO. 21213
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1 .00	
	Registr	ar	NOV 24 2009 Cereus D.	Carro	

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	partment of F artificate of E			giene Reg. No.2009	37629
	Physicia	n/	1. Decedent's Name (First, Middle,		0			2. Date of Dea	ath	3. Time of Death
	Medic	al	4a. Facility Name (if not institution,	Marie	Kev.		Location of Death	Novembe	4c. County of De	
	Examin	er	Union Memori		al	Balti			4c. County of Dec	auri
	Funeral		,	6. Sex 7. Age 1 ☐ M 2 🔀 F	e (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sep	h g. B	irthplace (State or Foreign ountry) Maryland
	Director		213-38-6423 Usual Residence of Decedent		03 frs.			Sep	28, 1940	Maryland
vland	f shored	ctor	10a, State 10b, County		10c. City, Town or L					10d. Inside City Limits
e Mar	r 28a- notifi	Director	MD 10e. Street and Number		Baltir	10f. Zip Code			10g. Citizen of What C	
with th	s 23a c ust be	Funeral	4231 Nicholas	Ave.		2120	6		United	
36 after death	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status  1  Never Married 2  Marrie	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
<b>6</b>	atural ical E	Completed by	3 ₩ Widowed 4 □ Divorced  15. Decedent		16a. Dec	edent's Usual Occup	ation	-	16b. Kind of Busines	
215 in 72 I	han "r Med	dmo	(Specify only highes Elementary/Seconday (0-12)	t grade completed)  College (1-4 or 5	+) life.	e kind of work done o DO NOT use retired)	luring most of work	ing		
7 5 E	Hygien ther t	Be C	12 17. Father's Name (First, Middle, La	leef)	Ho	ome Maker	18 Mother's Nam	e (Firet Middle	Own Hon	ie
	rked c	10	John Joseph Q					, ,	th Ellingha	us
Maryland 21215-0036	alth and N 27 is ma	1	19a. Informant's Name/Relationshi Kelly Gilden						r, City or Town, State, 2	
Baltimore,	nent of Hea int: If item iry or othe		20a. Method of Disposition  1			position (Name of ematory or other place		Nov 23 2009	20c. Location - City of Beltsvi	or Town, State
Balti	Departra Importa any inju		21. Signature of Funeral Service Lie	censee Moll	143	22. Nan <b>@_eein/adt</b> e			ternatives Towson Mar	yland 21286
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or						rest,	Approximate Interval Between
	ysician/ Medical	ì	Immediate Cause (Final disease or condition resulting in death)	a. Ure	nuc Er	rephal	operu	1		Onset and Death
	xaminer			Due to (or as a	a consequence of):	enal F	aune			Years
T . D	#	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	D. Due to (or as a	nic Er a consequence of: onic Ru a consequence of: dev an	1 000,0	cal to	h		Years.
de de	and il-trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last		a consequence of):	a cem		rucus	•	10075
e pe e	physician and s the burial-transit	edical		d						
3876 rtificat	ing ph		IF FEMALE:	00- 16						
Division of Vital Records, P.O. Box 68760 on the Hospital or Attending Physician: The law requires that the death certificate be executed.	signed by the attending d be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 S No 9  Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	ey		23d. Date of o	lelivery Day Year
S, P.O	signed by	d by Pr	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute Yes 2 No 3	to the cause of death?  Probably 4   Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the	his certificate has been si I director, page 2 should I	Completed							prior to rmed? death?	autopsy findings available o completion of cause of
tal F	ertifica ctor, p	Be C	25. Was case referred to medical examiner?	9 2			ace of Death (Chec		2 No 1 ⊔ Y	65 2 110
f Vi	this or	잍	1 Yes 2 No	Hospital:  1 Inpatie	ent 2 ER/Outpati		4 L Nursing H		dence 6 Other (Speciow injury occurred	ecify)
on o	ath. : After e fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, Day		work	Yes 2 □ No	Zod. Describe n	ow injury occurred	
Division Attent	s after des I Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 280 Place of Init	ıry - At home, farm, s :. (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
L Te Hospitz	within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	xamination and/or inve	estigation, in my opinio	on, death occurred a	it the time, date a	and place, and due to the	e cause(s) and manner stated.
To th	Vith Com		29b. Signature and title of certifler			29c. License			29d. Date signed (Mor	
			20 Name and address of never	the completed series of d	M.D	Print) ( La Sa	43894	0 1	Jovember	21, 2009
	3 Sta		30. Name and address of person w  FARAH S  31. Date filed (Month, Day, Year)	32. Recient	eath (Item 23a) (Type,	2016	Universi	ty Park	way; Baltin	riemo giais
	Registra		NOV 9	4 2000	B	A . 10 0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6,18 per fh g897 11-24-09 yt State of Maryland / Department of Health and Mental Hygiene 37630 Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER MYRA 11:40 A M ROSEMAN 2009 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE NORTH OAKS HEALTH CENTER PIKESVILLE 5. Social Security Numbe Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Hours Min Country) 09-16-219-21 218-14-7780 88 MD Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 🗆 Yes 2 💢 No **BALTIMORE** PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE. #512 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔊 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed 3 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ye 1 and 2 should be filed within 7/2 t of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 JOHNS HOPKINS RESEARCH ASSOCIATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev ပ FRANK IDA - UNKNOWN GOLDENBERG FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT. WILSON LANE. MORRIS ROSEMAN/HUSBAND #512, PIKESVILLE. MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CREMATION, INC.11-23-2009 HAMPSTEAD, MD CARROLL 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROTHERS. 8900 REISTERSTOWN ROAD, PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy 2 No 1 🗌 Yes ☐ Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 XOther (Special Control of the Contro this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Marner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Certifying Nurse fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29c. Licenşe number Itom 23a) (Type, Print imove 752/29 31. Date filed (Month, Day, Registrar's Signature State Registrar

			For Amend It State Registrar	ems 28e, f per i	aryland,	Departm 7,11724) Certific	ent of Hea ate of De	dth and M ath	ental Hyو ا	giene Reg. No. 2009	37631
	Physicia	an	1. Decedent's Name (First, Willie						2. Date of Dea	ath Day Year	3. Time of Death
	/Medic	al		suggs titution, give street and number)		4b. 0	City, Town, or Loc		Jovembe	4c. County of Deal	10.00
	LAAIIIII	CI		ital of Balt	Fimore	e E	altimi	ve Cit	Y		
	Funeral Director		5. Social Security Number 212-16-844	479Cu o 🗆 =	e (In yrs. last 88	birthday) If Ui Mon		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Day Nov	9. Birt V. Year) 01, 1921 S	thplace (State or Foreign outh Carolin
and	MC .		Usual Residence of Deceder 10a. State 10b. C		10c. City, To	own or Location					10d. Inside City Limits
Maryl	a-f sho	ţoţ	MD			ltimore					1 Yes 2 No
$\mathcal{G}_{\mathcal{G}}$ $\mathcal{S}$ with the Maryland	or 28g	Director	10e. Street and Number		L	10f.	Zip Code			10g. Citizen of What Co	
Jy S	is 23a	Funeral	3804 Grant		Fuer in 11 C	10 Mine D	21215	nia Ozinina (Cna	sife. Van au Na	United S	
ATRACT FROWN 25 WILE SUG Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with 11	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the friedical Exercitive must be multiled at once.		11. Marital Status  1 Never Married 2  3 Widowed 4 Div	If Yes Give			ecedent of Hispai specify Cuban, M s 2 <b>X</b> No <i>S</i> p	nic Origin? (Spe lexican, Puerto F pecify:	Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0 5-0 72 ho	natura dical E	eted	15. De (Specify only	cedent's Education highest grade completed)	1	6a. Decedent's l	Usual Occupation	n a most of workin	na i	16b. Kind of Business/	Industry
121 within	than "	Completed by	Elementary/Secondary (0		+)	Mechar	f work done durin T use retired)	g	.9	Automoti	_ve
2 br	other	Be Co	17. Father's Name (First, M		<u> </u>			Mother's Name	(First, Middle,	Maiden Surname)	
ylar ylar	Menta larked latic el	10 E	Unk Unk					Unk U			
√γς Mar	alth and 27 is m or traum		19a. Informant's Name/Rel Elizabeth	ationship <i>(Type. Print)</i> Wright /Cousin	1		1			er, City or Town, State, I re, MD 2121	, ,
more,	ent of He nt: If item ry or othe		20a. Method of Disposition 1 □ Burial 2 ★ Crema 4 □ Donation 5 □ Ott	ation 3 Removal from State	ceme	of Disposition ( etery, crematory	Name of or other place) Cremato	-	Nov 20 2009	20c. Location - City or Beltsvill	Town, State
Salti Talti	Departm Importar any injur once:		21. Signature of Funeral Se		10158					ernatives	
<b>S</b> • • •	ă <b>E W S</b>		Kelbecce	- Hockemer	~	87				Towson Mary	
Phy	ysician		shock, or heart failure Immediate Cause (Final	se, or complications that caused . List only one cause on each lin	ithe death. L				r respiratory ar	rest,	Approximate Interval Between Onset and Death
/IV	Medical		disease or condition resulting in death)	a. Due to (or as	a consequen		nator	100	A28 156	0	1.5 days
Exa	aminer	e.	Sequentially list conditions,	b. Due to (or as	e ecoes victor		_	1	led	NO)	
cuted	ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duc to (or as a	a consequent	de ory.		1 Du	TO BY MEDICAL	EXAMINA	
50, be exec	physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):		FICATION APPROV	leo-		
12. <b>68760,</b> tificate be exe	g physi is the b	edical		d			CERT		, ,		
Box	ne attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No	nt 23c. If yes, outcome  1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3 🗆 Ector	oic pregnancy r (specify)			23d. Date of de Month	livery Day Year
That the	ed by the		9 ☐ Unknown  Part II. Other significant co	enditions contributing to death but	ut not resulting	g in the underlyi	ng cause given in	Part I	23e. Did to	bacco use contribute to	the cause of death?
rds,	been signed by the should be detached	2					J J		1 □ Y	′es 2 No 3 P	robably 4 🗌 Unknown
Beco	has bee	Completed	·						24a. Was autop	sy prior to	utopsy findings available completion of cause of
ral F	ficate or, page		25. Was case referred to m	adical					perfor 1 □ Yes	rmed? death? 2 No 1 ☐ Yes	2 □No
f Vii	is cert directo	To Be	examiner?	Hospital: . /	ent 2 ER/	Outpatient 3 □	Othor	Place of Death  Nursing Hore		<i>ne)</i> lence 6 □Other <i>(Spe</i>	cify)
Division of Vital Records,				28a. Date of Injure (Month, Day	ry 281	b. Time of Injury	28c. Injury at Work? 1 □ Yes	2		ow injury occurred	-1
ViSic r Atten	rector: by the	Certification:	3 ☐ Suicide 6 ☐ C	auld not be	ary - At home,	farm, street, fac		2	8f. Location (S	Street and Number or R	ural Route Number,
Di pital on	eral Dil				Nursin	g Home	and at the discourse	R	andalls	T Court Roastown, Mary	Land
e Hos	e Fundelely	Medical		rtifying Physician: To the best of dical Examiner: On the basis of and manner sta	f examination						
To th	To th	Me	29b. Signature and title of c	1: 1:			29c. License nur			29d. Date signed (Mont	
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-0			The second second	erson who completed cause of de let let let let let let let let let le	eath litem 23	a) (Type, Print)	of Bal	L. wore	24011	W. Belvedere	Avenue
	Stat Registra		31. Date filed (Month, Day,	Year) 32. Registra	ar's Signature	backer	7			De Minnes	Avenue e, Wil 21215

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

13621

Baltimore Avenue Courel Mary

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

MI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7 Physician/ CHAPLES SCHRAUDER veromo 06:02 AM Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIM JOHNS HOPKING BAYNERU MEDICIAL CENTO N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs Days 1 X M 2 - F Months Hours **Director** 83 214-22-4630 Maryland Usual Residence of Decedent ge 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. If item 275 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 o No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 7902 St. Gregory Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married Yes, Give Maryland 21215-0036 2 - No 1 ☐ Yes 2 X No Specify: 3 Divorced WWII White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Millwright Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Genevieve Schuabel George Schrauder permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Dolores Schrauder 7902 St. Gregory Drive Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 11/24/2009 4 Donation 5 Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland . Part 1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician REIVAL disease or condition CHRONIC Medical resulting in death) Examiner PERIPHERAL Sequentially list conditions, if any, leading to trainediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed HYPERTENSION signed by the attending physician and I be detached for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month 4 Pregnant at time of death 9 Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FRIBILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No 1 Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Sigr

31. Date filed (Month, Day, Year)

Easte

4940

strar's Signature

of who completed cause of death (Item 23a) (Type, Print)

2009

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** vovember /Medical 4c. County of Death ity Name ( not institution Examiner Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Maryland 81 214-24-1350 March Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 21236 items 23a 12 Open Gate Court Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 jo. If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Marie Catherine Kiel James David Ellis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3707
3703
0akfalls Way Nottingham, Md. 21236 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 s Department of Health ar Important: If Item 27 is <u>Patricia Ehrlinger</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-21-2009 4 □ Donation 5 □ Other (Specify) Dulaney Valley Timonium, Md. 21. Signature of Funeral Service Lig 22. Name and Address of Facility any Ir Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. Approximate Interval Between Onset and Death 23a. Rem. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.0. 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 100 24a. Was an 1 □Yes 25. Was case referred to medical examiner? No the name within 24 hours after death.

To the Funeral Director: After this certifica 26. Place of Death (Check only one) Other: 4 🗀 Nursing Home Hospital: 1 Yes 2 100 spital: 1 In patient 2 ER/Outpatient 3 DOA
28a. Date of Injury
(Month, Day, Year) 28b. Time of Injury
28c. Time of Injury 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 [A Natural 2 ] Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number

Registra

State

# 1 - Stat Reg 1. Deced Physician /Medical Examiner 4a. Facili 300

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, its Medical Expriser must be rediffed at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar		State of Mar		•	cate of D			Reg. N	200	
Decedent's Name	e (First, Middle, Last)						2. Date of D Month	D	ay Yea	
Joan L.	.Sullivan						Novemb		0,2009	7:45A
4a. Facility Name (I	f not institution, give s	street and number)		4b.	City, Town, or L			4	c. County of De	
		Unit G				tingham				Balto.
5. Social Security N		7. Age	(In yrs. last birth	Mo	Inder 1 Year Inths Days	If Under 24 Hrs Hours Min.	. (Month, I	Day, Yea	r)	Birthplace (State or Forei Country)
212-30-17	/44	1 W 2 L21 / /	Υ	rs.			March	28,1	932 Ma	ryland
Usual Residence of 10a. State	Decedent 10b. County		0c. City, Town	or Location						10d. Inside City Limi
	TOD. County		oc. Oity, Town	or Location						1 □Yes 2 🛣 N
Md.	Ba1	to.			tingham					
10e. Street and Nur	nber				f. Zip Code			10g. C	Citizen of What	Country?
Md.  10e. Street and Nur  3901 Hann  11. Marital Status  1 Never Marri  3 Widowed  (Spec	non Ct. U	Init G			21236				uSA	
11, Marital Status		12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was I If Yes	Decedent of His , specify Cuban	panic Origin? (\$ , Mexican, Puer	Specify Yes or I rto Rican, etc.)	No-	14. Race - A Black, W	merican Indian, hite, etc.
1 Never Marri	ed 2K Married	1 ∐Yes 2 🔯 No If Yes, Give			es 2 <b>X</b> No	Specify:			Specify:	White
3 Widowed	4 Divorced	Year or Dates:			71			-,	J	
(Spec	15. Decedent's Educ	cation e co <i>mpleted)</i>	16a. I	Decedent's	Usual Occupat of work done du OT use retired)	ion ring most of wo	rking	16b.	Kind of Busine	ss/Industry
Elementary/Seco		College (1-4or 5+)								
121	th		Co	ommun	<u>ication</u>					Square Hospi
17. Father's Name	(First, Middle, Last)				1		me (First, Midd		en Surname)	
Dominio	c J. Wynne	2				Audre	y Coona	n		
	ame/Relationship (Ty)	pe. Print)	19b.	0	,		lural Route Nun	-		
John St	ıllivan	SI	oouse	39	01 Hann	on Ct.	Unit G	Noo	ttingha	m, Md. 2123
20a. Method of Disp			20b. Place of I	Disposition	(Name of y or other place,	1	Date	20c.	Location - City	or Town, State
1 Burial 2	☐ Cremation 3 ☐ R 5 ☐ Other (Specify)	Removal from State	Parky		y or ourer place,		23-2009	Par	kville.	Md.
	nerał Service License	117	raiki		ne and Address		Schimun		-	
21. Signature of Ed	ne Service Licers				05 Bela				, Md. 2	
7	1 000	ications that caused th							110. 2	Approximate
Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nditions, mediate rtying injury ast	Due to (or as a difference of the control of the co	STAT consequence of	7e (	HOLA	11-6100	CARCIA	to M	A	5 mos
IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown Part II. Other signit	months?	23c. If yes, outcome of 1  Live birth 2 4  Pregnant at ti 9  Unknown	Fetal death		opic pregnancy er (specify)			-	23d. Date of Month	delivery Day Year
Part II. Other signif	icant conditions cor	ntributing to death but	not resulting in	the underly	ing cause giver	ı in Part I.	23e. Di	d tobacc	o use contribut	e to the cause of death?
							1[	] Yes	2 <b>□ N</b> 0 3 □	Probably 4 Unknow
							24a. W	ac an	24b Mere	autopsy findings availat
							au	topsy	prior	to completion of cause of
							1 □Yes		1 0	res 2□No
25. Was case refer examiner?		In a side la					eath (Check onl	y one)		
1  Yes 2	INU	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/Out	patient 3	□ DOA Other	4 Nursing	Home 5 4	sidence	6 ☐ Other (5	Specify)
27. Manner of Deat 1 ∰Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day,	Year) 28b. Ti	me of jury	28c. Injury Work? 1 🗆 Y	at es 2 □No	28d. Describ	e how in	jury occurred	
3 ☐ Suicide 4 ☐ Homicide	6   Could not be determined	28e. Place of injury building, etc.	/ - At home, far (Specify)	m, street, f	actory, office		28f. Location City or 1	(Street Town, Sta	and Number of ate)	r Rural Route Number,
29a. Certifier (Check only one)		rsician: To the best of iner: On the basis of e and manner state	examination and							
29b. Signature and	fitle of certifier	1001			29c. License			29d. I	Date signed (M	onth, Day, Year)
MIL	Man P.	Mi Au	we R	40	010	0801		1	40020	2009
30. Name and addr	ess of person who co	M- Au ompleted cause of dea	ath (Item 23a) (	Type, Print	Balti	n No.	No	2/2	257	
31. Date filed (Mon		32. Registrar								

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

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Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral C

> State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, 5

Basker

Baltimore

Fellow

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

Year)

4

29c. License number

128580 20091

ALBERT

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29d. Date signed (Month, Day, Year)

11/20/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20,2009 Harold Sherman Jr. November 10:00  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Genesis Eldercare Dundalk Heritage Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 1**X**XM 2 □ F 190-18-4265 Director 1924 85 Movember 6. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1216 Hillshire Road 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or 1 Never Married 2 Married 2 No Completed by 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: than "natural", Specify: White 3 X Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wire Puller Steel 12 years marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leroy Harold Sherman Sr. Anna Schober 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Bingaman Daughter 1216 Hillshire Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot November Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2009 Dundalk, Maryland Oak Lawn Cemetery 23, Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Signature of Funeral Service Licensee TICKO 23a, Part 1. Enter the dise see or complications that caused the demandance, or heart failure. List only one cause the each list. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) CARDIOVAS CULAR DUSATE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exam and Due to (or as a consequence of) resulting in death) Last physician a s the burial⊣ Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death signed by the a ld be detached f 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Division neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month

Box 68760

P.O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 17, 2009 Barbara Smith Anna 3:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Essex Riverview Nursing Home Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours March 23,1928 1 🗆 M 2 😿 Maryland Director 81 212-26-9610 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director Dundalk Baltimore Marvland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7405 Holabird Avenue United States 21222 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married Completed by 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Madeline Suderland Artley Benny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8096 Forest Hill Drive Ellicott City, MD 21043 Regina Yurek (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State At. of Jesus Cem. 3/23/1928 4 Denation 5 Other (Specify) Sagred. Dundalk, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk. Maryland Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ediate Cause (Final ase or condition Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 2 🗌 No as been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? page death? 2 1 No 1 Yes Yes 2 N Division of Vital funeral director, 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred tural Accident 5 Pending n 24 hours after death. le Funeral Director: Aff bleted filled in by the fur 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 **To the I** only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

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State Registrar of person who completed cause of death (Item 23a) (Type

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 37639 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vear MALCOLM SHERMAN NOVEMBER 19 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BROADMEAD COCKEYSVILLE BALTIMORE Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/05/1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-18-4120 Months Days Hours 1**X** M 2 □ F 87 Director Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be riotified at Director 1 ☐ Yes 2 X No MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10g. Citizen of What Country? 13801 YORK ROAD. 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE δ If Yes, Give Year or Dates: Specify 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "r. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) **OWNER** REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be 1 Health and Mental ABRAHAM SILVERMAN HELEN LIPMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trauonce. WENDY SHERMAN/DAUGHTER 6207 YORKSHIRE TERRACE, BETHESDA, MD 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 11/22/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOLLEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Signatur of Funeral Service Line Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) dan /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐Yes 2☐No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 Z/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perFH G898 12/4/09 WS
State of Maryland / Department of Health and Mental Hygiene amend item 7 per fh 2898 12-15-09 vr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day NO VENIBER Physician/ Leon Tirk 10:92 AM 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore n/a 8. Date of Birth 7/1 1/1942 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex... 1 M 2 F 7. Age (In vrs. last birthday **Funeral** Hours Min. (Month Dayo Yea 67 220-36-8000 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore n/a 1 🔽 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4029 Reisterstown Road 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No African-American Specify: 3 DWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Palletizer Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Berkley Tuck Annie Brunson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose A. Turk/Wife 4029 reisterstown Road, Baltimore, MD 21215 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-28-09 Woodlawn, MD Woodlawn Cametery 21. Signature of Funeral Service, 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 LibertyRoad Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, day disease or condition resulting in death) Medical Due to (or as a e nsequence of): Examiner Monte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as consequence of the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 - No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Acciden Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ani Kulkam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOMORIAL 31. Date tile 🕽 Von i Registrar' State Registrar

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed P.O. Box 68760 Division or Vital Records, To the Hospital or Attending Physiclan: ours after death.
neral Director: A
filled in by the for within 24 hours a completely

to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier

D 21392

29d. Date signed (Month, Day, Year) November 23, 2009

30. Name and address of person who completed cause of death (I)em 23a) (Type, Print)

Patricia D. Kellogg, M.D. 201 Seven Locks Road, Suite 111, Rockville, MD 20854 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a, Certifier

(Check only one)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth **Physician** Herman J. Travers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Balto. Loch Raven Center If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 218-03-1958 89 August 30,1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Md. Balto. Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9022 Perryvale Rd. 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Folices: 1 X Yes 2 □ No If Yes, Give Year or Dates: 1942–1945 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Postal Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Buenger Wilhelmena ပ Bosse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md, 21236
Date 20c. Location - City or Town, State Frances Travers Spouse 9022 Perryvale Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 11-23-2009 Balto. Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reprai Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify)

**Physician** /Medical Examiner

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be ready Injury or other traumatic event, the Medical Examiner must be ready injury or other traumatic event, the Medical Examiner must be ready.

Maryland 21215-0036

Baltimore,

requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division or Vital

or Attending

the Hospital

0

burial-trar attending physician Physician/Medical the as for the signed by the þ Completed page 2 should certificate has Be ပ this funeral Certification: After t within 24 hours at er death. To the Funeral Director: A

9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1.X. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Medical 29b. Signatufe and title of certifier

address of person who comp

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

A ROCKITLE MA 20850 HUM

Registrar

filled

31. Date filed (Month, Day, State 24 2009 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 1 PM /Medical Facility Name (If not institution, give 4c. County of Death City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) Marylar 5. Social Security Number 6. Sex (In yrs. last birthday **Funeral** Hours 1 № M 2 🗆 F 215-58-590 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
amy hinry or other traumatic event, the Medical Examination at the motified at
once. 1 ☑Yes 2 ☐ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Oakhill Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Fes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) one Improvement Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thompson 1006 E. Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hep B 4 Etor Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached Ö 9 Unknown 9 Unknown signed by to ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 2 **Y**No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending death. investigation 1 □Yes 2 □No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 146768 7657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREA HUANG 31. Date filed (Month, Day, gistrar's Signature 24 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 9 376							
Physician/ Medical	/	1. Decedent's Name (First, Middle, Last) Daniel Martin Twome	2. Date of D Month Novein			Day Year 1.12 D			
Examiner		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice		4b. City, Town, or Location of Death			4c. County of Death Baltimore		
Funeral Director	4	5. Social Security Number 6. Sex 131-34-7239 6. Sex $1 \boxtimes M \ 2 \square F$ 7. Age (In yrs. last bine)	rthday) Yrs.		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Day 2/28/		9. Birti Cou NOW	hplace (State or Foreign Intry) YOCK
land show dat	- 1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tox							10d. Inside City Limits
the Mary or 28a-f e notifie	2	Maryland Baltimore Re  10e. Street and Number	iste	rstown 10f. Zip Code			10g. Çitizen o	of What Co	1 ☐ Yes 2 1 No untry?
leath with the Maryland items 23a or 28a-f shoer must be notified at Ermaral Director		12607 Mount Laurel Court  11. Marital Status 12. Was Decedent Ever in U.S.	13 V	21136  Was Decedent of Hispanic Origin? (Specify Yes or No-			109. Citizen of What Country? United States Of America  14. Race - American Indian,		
° 5.9		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	"	Yes, specify Cuban, M  ☐ Yes 2 ☑ No St	lexican, Puerto F	Rican, etc.)		lack, White	
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or amyorizent: If item 27 is marked other than "natural", or other traumatic event, the Medical Examinated.  To Re Completed by		15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+) 12 5+	(Give I	ent's Usual Occupation ind of work done during NOT use retired) Attorney		ng	16b. Kind of	Business I ∂W	ndustry
land in the filed very the other of the countries of the countries of the To Reference in the countries of t		17. Father's Name (First, Middle, Last) Daniel Twomey		18.	. Mother's Name Margar	<i>(First, Middle,</i> et Finn		me)	
re, Maryla 1 and 2 should be f Health and Men item 27 is marke other traumatic	Ì	19a. Informant's Name/Relationship (Type, Print)  Mrs. Mary Agnes Twomey/ wife  19b. Mailing Address (Street and Number or Rural Route Number, City or To 12607 Mount Laurel Court Reisters							
imore, Page 1 and nent of Heal ant: If item 2 ury or other		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of		ate	20c. Location		
Baltimo permit. Page Department of Important: If any injury or once.	ŀ	1   Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)   Chapel - Rel Air   19, 2009   Forest Hill, Maryland   21. Signature of Funeral Service Licensee   22. Name and Address of Facility   eaceful Alternatives Funeral & Cremation Ctr., P.							on Ctr.,P.A.
	1	23a. Part 1 Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	Timonium, Mary respiratory arrest,		aryla	Approximate Interval Between			
Physician Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence	Colon Cancer					Onset and Death	
Examiner	2	Sequentially list conditions, if any, leading to immediate cade. Early Underlying.  Cause (Disease or imjury	of):					-	
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760 cate be ex physician s the buria	Bolloo	d							
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.  Medical Certificate: To Be Completed by Physician/Medical Exam	ly slotally le		1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)				23d. Date of delivery Month Day Year		
dS, P.O. quires that the signed by huld be detacted.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Y Unknown			
Division of Vital Records, tal or Attending Physician: The law requires is after death.  I director After this certificate has been signed in by the funeral director, page 2 should be Centrificate: To Be Completed.						24a. Was a autop perfo	rmęd2	prior to o death?	opsy findings available completion of cause of
Vital II hysician: 1 his certifica I director, p	3	25. Was case referred to medical examiner? 1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   No   Yes   2   No   No   Yes   2   No   No   Yes   2   No   No   No   Yes   2   No   No   No   No   No   No   No							
Mn of Inding Physics After this funeral cate: 7			Time of injury	of 28c. Injury at 28d. Describe how injury occu				6/	
NISION OF lor Attending P firector After t lin by the funera		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		et, factory, office	3f. Location (Street and Number or Rural Route Number, City or Town, State)				
he Hospita in 24 hours he Funeral ipleted filled	Icalica	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To th Within		29b. Signature and title of certified  Mani Aut (RNP)	29c. License nun						
2+1	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marian Grant, G201 N. Charles St. Towson, MD 21204							
State Registrar		31. Date filed (Month, Day, Year) NOV 2 4 2009  32 Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37645 State of Maryland / Department of Health and Mental Hygien State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month YOUEMBE Physician/ JEANETTE IET KOWSKI 17:45PM 0 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns HOPKINS Baltimore BAYVIEW MEDICAL CENTE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 F Months Hours Min. (Month, Day, Yea Country 1914 Director 214-30-7334 10 January Maryland Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Baltimore Md. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7411 Holabird 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**x** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Packer Lever Brothers vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Haves Della Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 Four Georges Court, Apt.A4 Balto. Md. 21222 Son Norman Harvel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō November any injury Baltimore, Maryland Bayview Crematory 2009 24 gnal re of Fun al Service Licens 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, 23a. Part 1. Enter the disease, for complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) STROKE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown Month Year Pregnant at time of death cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? yes 2 No certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ Impatient 2 🗌 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work' 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nerse Prantianer: To the best of my knowledge, death consend at the time, date and plane, and due to the newsels) and manner as wave. 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 20, 2009 RES - 00 1 30. Name and address of I son who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALLIMONE NG KWAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 37646 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20<sup>Day</sup> 2009 **Physician** No Wonth 4:50A M Mary Gertrude Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Nursing Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/18/1915 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 F Days 218-12-0242 94 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or Itams 23a or 28a-f show the Medical Exemple 1, but to notified at Baltimore MD Parkville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2820 Garnet Rd. 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Tes 2 Tools If Yes, Give Year or Dates: 1 Never Married 2 Married White 0 Baltimore, Maryland 21215-0036 1 Yes 2D No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail Elementary/Secondary (0-12) College (1-4or 5+) Sales Woman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Albert Simms Mary A. Bucher 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Vaught/Daughter 2804 Chenoak Ave. Parkville, MD 21234 20b. Place of Disposition (Name of Nov. 23, 20c. Location - City or Town, State 20a. Method of Disposition Chesapeake Crem. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Beltsville, MD 2009 21. Signature of Funerat Service Licensee 22. Name and Address of FacilinCAFA/Stephen D. Lohrmann P. A. 8717 Green Pastures Dr. Balto, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death Immediate Cause (Final ALZHEMER'S DEMENTA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ADRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HEART FAILURE CONGESTIVE autopsy performed 3 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 3 No 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) D28987 who completed cause of death (Item 23a) (Type, Print) LOCAL RAVEN BLUD SPERUNG M.P. 5601 31. Date filed (Month, Day, Year) 32. Rigiskar's Signature State Registrar

DHMH 17 Rev 1/2001

TODD, Genevieve

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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r death or item uiner m	Completed by Fur	11. Marital Status 1 ☐ Never Marrie	nd 2 Marr		Decedent ed Forces Yes 2	t Ever in U.S	n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					ecify Yes or No- Rican, etc.)	-	14. Race Black	- America	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Nan										nton, Mai				ode)
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To the within com		29b. Signature and the	le of certifier	2 1	m	1)		29c.	License +8	number 006			29d Dat	te signed (	Month, D	ay, Year)
		30. Name and addres	s of person w	tho completed	cause of	death (Item	23a) (Type, P	rint)	ita	.)	Dr	16	سوا	B	m;	(m)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37648 Reg. N2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month RLES 405 A M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Cheaspeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 88 Yrs. Funeral Months 1**X** M 2□ F 214-14-3965 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Department of Health and Mental Hygiens in the incurson cause overall with the Maryla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations in the notified at once. MD 1 ☐ Yes 2 No Director Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 406 Linwood Ave 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify. Š Specify: White 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service US Gov't 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles John Urban Anna Mary Franz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Urban (Son) 2503 Loramae Ct Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatign 5 ☐ Other (Specify) Air Mem. Gardens 11-25-2009 Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Lice ee Inc 610 W. MacPhail Rd BelAir MD 21014 23a. Part If Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached it 1∐Yes 2∐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 1 ☐ Yes 2 🗆 No 2**′√**No 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2√ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ŧ To the Funeral Director: After th completely filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier D0066409 11, 21, 2009 500 UPPER CHEST PEAKE DR BEL AIR, MJ 21014

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

amend items 20h Department 898 eligh and Merital Hygiene Reg. N2 009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7=30Pm 2009 Melanie Vines /Medical 4c. County of Death 4b. Cify, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Specialty ttospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-31-73 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 36 yrs **Funeral** Days MD 219**-**82-2153 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland 10b. County sa or 28a-f show t be notified at 1 ☐ Yes 2X ☐XNo Owings Mills Funeral Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 "natural", or items 23a 155 Royalty Circle 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Evamina Black, White, etc. African 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Be Completed by American 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Bayada Nursing Ctn. 4yrs. Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Deborah Vines Paul R. Brown ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 155 Royalty Circle Owings Mills, MD 21117 Mylesha Murray-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Line Com 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne 11-28-09 Anne Arundel 4 Donation 5 Dother (Specify) 11 Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. <u>638 N. Gilmor</u> Street Baltimore, wert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiration Physician /Medical Due to (or as a consequence of Examiner ESRD Sequentially list conditions, living leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner whalaund hemother Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day In the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A bletely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tou Thave 21/09 MD. Php D0066903 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dou Zhang Etlicott City Pee 4018 Jay 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37650 1 - State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Otis November 19, 2009 Vessels 2:07 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2 □ F Months Days Hours Min. 579-46-9936 Director 74 04-05-1935 Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Md. Prince Georges Mitchellville the 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mydfall Exprintment ust be noone. 10f. Zip Code 10g. Citizen of What Country? 11408 Trillum Street Funeral 20721 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Transit Driver Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Earl Vessels, Sr. Katie Lindsey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry M. Vessels - Wife 11408 Trillum St., Mitchellville, Maryland 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jerusalem Bapt. Cem. |11-28-2009 | Sparta, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signatur) of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home enal I 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) a Hemorrhogic Shock /Medical Due to (or as a consequence of): **Examiner** Acute Gastrointestinal Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 3 Ectopic pregnancy in the past 12 months? Month Dav Year 1 ☐ Yes 2 ☐ No 5 Other (specify) o the detached 9 Unknown 9 Unknown ģ σ. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Dementia with paranoid psychosis atrial flutter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate perform 2 X No 1 ☐ Yes 2 🖾 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation after death Director: A 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral D etely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital the Hospital or Attending 24 hours the 0

completely

State Registrar

Medical

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shailesh K. Sheth, M.D. - 1500 Forest Glen Rd., Silver Spring, Maryland 20910

32. Registrar' Signatur

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D52503

29d. Date signed (Month, Day, Year)

November 20, 2009

			1 - For State Registrar	State of Ma	-	epartment of F Certificate of		ental Hyوا/ ا	giene Reg. No 200	9	37651
	Physic	ian	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ath	Year	3. Time of Death
	/Medi		Albert T. Va					Novembe	r 20, 20	09	9:14 A <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution,	•		, ,	r Location of Death		4c. County o		
	Funeral	•	Greater Baltin  5. Social Security Number 6		(In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Balti		ace (State or Foreign
	Director		102-09-1995	1 ☑ M 2 □ F		Yrs. Months Days	Hours Min.	(Month, Day 11/13/	y, Yea <i>r)</i> 1917	Couintr Nev 1	
	and •		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
	the Marylan r 28a-f show notified at	to	Maryland Baltin			MONIUM					1 □ Yes ŽŽNo
	with the 3a or 28g	Funeral Director	10e. Street and Number 205 Belluont Ford	est Count Un	it 101	10f. Zip Code 21.093			10g. Citizen of Wh United	nat Countr State	
70	hours after death with the Maryland tural", or items 23a or 28a-f show at Exmiti or must be notified at		11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give		13. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☒ No	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black,		n Indian,
28	72 hours "natural";	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a.	Decedent's Usual Occur	pation		Specify: 16b. Kind of Bus	iness/Indu	
215	within 72 ene. than "na he Madi	ple	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+		(Give kind of work done life. DO NOT use retire	during most of work	ing			gineering, &
42	ed wil lygien <b>rer th</b>		12	5		Owign			Assembly		oany
Jang	2 should be filed w n and Mental Hygie 'is marked other t raumatic event, h	To Be	17. Father's Name (First, Middle, La Gustav Va	· ·			18. Mother's Name Pharali	e (First, Middle, .de Vall		)	
Mary	ges 1 and 2 should be filled within 72 ho t of Heaith and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical	ľ	19a. Informant's Name/Relationship Mrs. Marilyn J.			Mailing Address (Street 5 Belmont F					
Vancuisem Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trainonce.		20a. Method of Disposition  1 □ Burial 2 □ ICremation 3  4 □ Donation 5 □ Other (Spe		cemetery LVallS	Disposition (Name of y crematory or other place   This is a large of the place   This is a large of the place	1	Date Einber 2009	20c. Location - C	•	m, State Maryland
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Lic		r Cuape	el-Bel Air Peaceful Al	ss of Facility Cernative	s Funer	al &Crem	ation	n Ctr.,P.A.
	Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_a. MR5/	Pineu	ot enter the mode of dyi	5 YOTK RO			ĺ	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b							
108	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C							
909289	icate be executed physician and the burial-transit	edical E	issuing in obtain, Edd.	Due to (or as a	consequence o	n):			····		
	certific ding p	/Mec	IF FEMALE:	220 If you guitage a	f prognancy.	<u> </u>					
O. Box	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the I	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	У		23d. Date Mont		y Day Year
ح.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions		not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the	cause of death?
ord	equire	ted	<u>Visidenal Ma</u>	22				1 🗆 Y	es 2 No 3	B□ Proba	bly 4 ☐ Unknown
ec.	elawı hasbı e2sh	Completed	Mahnutrition					24a. Was autop	sy pri	or to com	sy findings available pletion of cause of
<u>a</u>	ding Physician: The law h. After this certificate has funeral director, page 23		Bedbound St.	ate				perfor 1 ☐ Yes	med de	ath? □Yes 2	
Ζit	Physician: r this certific ral director, p	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		notions 2 DOA Oth	er:				
of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. T	ime of 28c. Injur	4 LI Nursing Ho		lence 6 Other		
ion	Attending or death.  ector: After by the funer	atio	1 Natural 5 ☐ Pending investigat		rear) In		K? Yes 2 □ No				
Division of Vital Records,	after de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, fari (Specify)	m, street, factory, office		28f. Location (S City or Tow	Street and Number rn, State)	or Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and	death occurred at the tid/or investigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and man date and place, ar	ner as sta nd due to t	ited. he cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	rurelt M	D	29c. Licens	e number	:	Novembe	(Month, Da	ay, Year)
	3		30. Name and address of person wh	o completed cause of dea	ath (Item 23a) (	Type Print)	4 3809 -	Tours 1	Novembe MD 212	04	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	s Signature	Shot Sur	AU DERV	IA NAT DAT	V V 4		
	Registr		NOV 24 4	1905 Karen	1 14. 1	7					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vaar **Physician** 12:50A M Helen Agnes Visocky November 17. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 848 Oakleigh Beach Road Dunda1k Baltimore Co. If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 😾 F Yrs Director Aug. 12,1930 Pennsylvania 165-24-7065 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Tes 2√ No Director Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21222 United States 848 Oakleigh Beach Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. I and 2 should be filed within 72 hours after dealth and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. White 3- Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Fastermeier Joseph Buchler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, Maryland 21014 1022 Southern Drive Adria Parnell (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Sacred Ht. of Jesus Cem 11/20/2009 Dundalk, Maryland 21. Signal ve of Funeral Service Cirensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Y 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Parts Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Diffuse large Bcall Physician ~ 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, o A My as thenia Gravis 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2 🗚o 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No al or Attendl s after death. Il Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0058893 17 November 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Kaltawae, 21224 Eastem 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARBARA 144 A M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 319 Main Street Anne Arundel Lothian Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Feb. 8. 1934 Months Days Hours Min. South Carolina 578-52-1449 Director 75 Usual Residence of Decedent fshow Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must <u>be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Lothian Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 319 Main Street 20711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. <u>چ</u> 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည F.C. Stokes Helen Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 183 Main Street, Lothian, Maryland 2071 Vicky Andrews/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Novemberte 20. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 22. Name and Address of Facilin Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 754ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of. Exami executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 Xio
9 Unknown or Attending Physician: The law requires that the death for Month Year Pregnant at time of death 5 Other (specify) the detached P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been signated to page 2 should to Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death, To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 W funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tes 2 1 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 No М Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatute and title of certifier 29c. License number 29d, Date signed (Month. Mame and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

			For State Registrar	e of Marylan			of Health <i>of Deatl</i>		-	giene Reg. No 2 (	009	37654
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
	Physici		Charles E. White Jr.						Month	19	Ye ar 2009	4:45 p. M
1	/Medi Examir		4a. Facility Name (If not institution, give street ar	number)		City, To	wn, or Location				nty of Death	10.00
			Dinai Hospital of	Baltimo	Ne	Bal.	timor	e (	tu			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1	Year If Under	er 24 Hrs. Min.	8. Date of Birt (Month, Da 12-17-	th v. Year)	9. Birth	place (State or Foreign
	Director		213-28-1357 1XM 2	79	Yrs.	WOTHING	Jays Hours	IVIII.	12-17-	1929		MD
5	pur M		Usual Residence of Decedent  10a. State 10b. County		10d			0d. Inside City Limits				
â	laryle sho	ō		100. 010	y, Town or Lo						1 Yes 2 □ No	
harles	the N 28a-i	ect	MD n/a  10e. Street and Number		Baltir	10f. Zip C	nde			10g. Citizen o	f What Cour	atry?
2	with with		5508 Fen park Avenue				21207			USA	T TTICL COU	y.
_	ours after death with the Maryland ral", or items 23a or 28a-f show Examing mast be rottified at	Completed by Funeral Director	11 Marital Status 12. Was	Decedent Ever in U.	S. 13. V			Origin? (Spe	cify Yes or No		ace - Americ	can Indian.
Pro	after o	Ξ	Arm 1 □ Never Married 2 Married 1 ∑	ed Forces? Yes 2 ☐ No			nt of Hispanic ( Cuban, Mexic		Rican, etc.)		lack, White,	
7,78	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Ye a	s, Give r or Dates:	,	1∐Yes 2∭X	]No <i>Speci</i> i	fy:		Spec	oify: ALTIC	an-American
₹2.5	72 hours after dear "natural", or items	ed	15. Decedent's Education (Specify only highest grade comple	ofod)	16a. Dece	dent's Usual (	Occupation	act of warkin		16b. Kind of	Business/In	dustry
27	within 7 lene. <b>than "</b>	nple	1, , , , , , , , , , , , , , , , , , ,	ege (1-4or 5+)	1		done during ma retired)		I		3 3 7 /	·
8,2	ed wi ygier <b>ner th</b>	S	1		Alcdroid	& Addict	ion Spec			Springfi		spitai
nd C	be fill ntal H d oth	Be	17. Father's Name (First, Middle, Last)				<b>I</b>	ther's Name nice Co	-	Maiden Surn	ame)	
25	rould be f d Mental I narked of natic eve	2	Carles E. White Sr.		T							
KNOWN AS e, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, "the Medical once.		19a. Informant's Name/Relationship (Type. Print Carita A. White/ wife	t)			Street and Num Avenue,				vn, State, ∠ıµ	Code)
, e Z	1 and 2 Health em 27 i	1 1	20a. Method of Disposition	20b. P					ate	20c. Location	n - City or To	own, State
Raltimore,	permit. Pages i Department of H Important: If ite any injury or of once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal		lace of Dispo emetery, cren Tison Fo			11-30-	ne l	Owings		
⋣	artme		4 ☐ Donation 5 ☐ Other (Specify)  1. Signature of Funeral Service Licensee	CAIL								Balto. Co.
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			23a. Parti Enter the disease, or complications	that caused the death			,	,	,		2	Approximate
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	/Medical		disease or condition resulting in death)	DEPSUS Le to (or as a consequ	lence of):							day
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	cuter nd ransi	Examiner	Sequentially list conditions, if any local and interest of the cause. Enter Underlying Cause (Disease or injury that initiated events c.	Hyperli	pide	mia						20 years
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8760,	icate be executed physician and the burial-transit	dical	d									
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σ.	that t ed by detac	H.	Part II. Other significant conditions contributing	g to death but not resu	ulting in the u	nderlying caus	se given in Par	t I.	23e. Did t	obacco use co	ontribute to t	he cause of death?
Sp	uires sign Id be	d b	Hypertension						12	Yes 2 No	3 □ Pro	bably 4 ☐ Unknown
00	v req	ete	Alzheimer's de	mentio					24a. Was	an 24	h Were auto	nnsy findings available
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<u> </u>	iffication, pa		25. Was case referred to medical				ac Die	as of Death	1 Yes	2 No	1 ☐ Yes	2 🖃 No
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<u>.</u>	ath. r: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, rear)	пјату	М	1 ☐ Yes 2	□No				
Division of Vital Records,	r Atte er de recto	Certification: To	3 Suicide 6 Could not be determined 28e.	Place of Injury - At ho building, etc. (Specif	ome, farm, str	eet, factory, o	ffice	2	8f. Location (S	Street and Nui	m <i>ber</i> o <i>r Run</i>	al Route Number,
Ö	ital or rs aft all Different a	Cer								,,		
	Hospi 4 hou uner	cal	29a. Certifier (Check only  1  Certifying Physician: 7 2  Medical Examiner: On	the basis of examina								
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) and	manner stated.			icense numbe					
	<b>5</b> ≥ <b>6</b> 8		29b. Signature and title of certifier	10						29d. Date sig		
			1 Jaske VI Wal	rou	20-\ (T		005761	9		Moven	150 2C	2009
11		1	3. Name and address of person who completed	cause of death (Item	1 ∠3a) (lype,	I of	Balto	na Ma	2401	WROL	bdor	21215
10,	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	4 01	July	MUIZ	2101	· · Lei	vener ?	م امدا ع
4	Registr		MOV 0 4 9000	0								

DHMH 17 Rev 1/2001

09-09033 Eric Wilkerson

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State of Maryland / Department of Health and Mental Hygiene

th and Mental Hygiene		2009	37655
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		For State		•		Certific	ate of	Death					Reg. No		UL		3/1	2 2
Physician edical Examine	1	Decedent's Name (First, Eric Brian V									- 1	Date of De Month	Day er 20,			171	e of Death 16 hrs	
	4	a. Facility Name (if not ins Northwest Hospita		e street and n	umber)		4	b. City, Tov Randall			Death			c. County of Baltimore		ounty		
Funeral	5	Social Security Number 216–84–0313	6. S		7. Age (Ir	n yrs. last bir	rthday)	If Under		If Under Hours	24Hrs.			I/DD/YYYY)	9. Biri Co	thplace ( untry)	(State or For	eign
Director	Ļ			M 2 F	L	46	Yrs.				<u> </u>	4-1-1	963				MD	$\dashv$
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r death with or items 23	1 Jera	Marital Status     Never Married 2	Married	12. Was De Armed F	Forces?			s Decedent es, specify					No-	White		ican ind	ian, Black,	
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ours at atural samin	<u> </u>	15. Decedent's Education		or Dates:		eted) 16a		t's Usual O					16b.	. Kind of Bus	siness/	Industry	1	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Ē,	12th 17. Father's Name (First, N	liddle, Last	)					18	.Mother's	s Name (	First, Middle	1	n Surname)				
215 be file ntal H; rked o	e l	Edward R. Will	erson							Bart	ara I	Nels	on		_			
D 21 hould and Me is man		19a. Informant's Name/Rel Barbara L. Will	ationship (			1		Address GwynnO						City or Town	n, State	e, Zip Co	ode)	
and 2 sho ealth and 2 sector 27 is traumati	L	20a. Method of Disposition		TOURL			of Dispos	ition (Name			ony	Date		. Location -	City o	r Town,	State	
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury by rother traumatic event, the Medical Examiner must be notified at once	1	Donation 5 Ott Signature of Funeral S	er Specify ervice Lice	nsee n			22. N	lame and A	ddress o	of Facility	Wli	e Fune	ral H	tome P.A	A. o	f Bai	ltimore	Co.
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Box 68 e death certif the attending		1 Yes 2 No 9		n g Unk	nown													
that the	by Phy	Part II. Other significant	conditions	contributing	to death b	ut not result	ting in the	underlying	cause giv	ven in Pa	art I.			_			use of death	
ords, P.C.												24a. W	/as an	24b.	Were a	autopsy	findings avai	ilable
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Vita hysician this cer	e Be	examiner?		Hospital: 1	Inpatient	2 🗸 ER	/Outpatien	t 3 DO	DA C	Other <sub>4</sub>	Nursin	g Home 5	Res	idence 6	Oth	er:		
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		29a. Certifier	ing Physi	cian: To the t	est of my l	knowledge,	death occi	urred at the	time, dat	te and pl	ace, and	due to the	cause(s)	and manne	r as st	ated.	(-)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	gic	one) 2 Medic		er:On the bas and manne	is of exami r stated.	nation and/o	or investiga			death or		t the time, o		place, and od. Date sign				
	Σ	29b Signature and title of	certifier	1	Λ			290	O.C.N					lovember			ay, rear	
	-	30. Name and address of	when wh	beet o	ause of de	ath (Item 23	a)										_	
1	1	Laron Locke MD		stant Medi				n Street,	Baltim	nore, M	/ID 212	01						
		31. Date filed (Month, Day	Year)	2009 32.	Redistrar's	Signature	1 1	iare	,									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) November 23, 2009 Physician/ 12:44A M Herbert Wilkerson, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Roundwood Road #403 12246 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Funeral Days Coul Mary land Months 6 Mr31/1934 75 219-28-0501 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Timonium 1 Yes 2XXNo 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral USA 21093 12246 Roundwood Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Salles College (1-4 or 5+) Printing Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Freund J. Herbert Wilkerson 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) Timonium, Maryland 12246 Roundwood Road #403 Mary Wilkerson / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Loudon Park Cemetery 11/27/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TOWSON, Maryland 21204 Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CAD area tielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death the hed g Unknown 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate Yes 2 W To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 🗆 Yes 2 🗆 No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 00016091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar nature

32. Registrar's S

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21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perfH,G904,6/2/2010,WS
State of Maryland / Department of Health and Mental Hygiene 2009 37657 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Physician/ Month Howard Lewis Wrightson, Jr. 19 6:08  $P_{\bullet}^{M}$ Nov. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson 5. Social Security Numb 214-50-240 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🖾 ¥M 2 🗆 F Months Days Hours Min (Month, Day, Director 62 Usual Residence of Decedent 28a-f show 10a, State 10b. County with the Maryland notified at 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Randallstown 1 ☐ Yes 2 🖾 No 10e, Street and Number 10f, Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 3904 Nemo Road 21133 United States items ? hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Repairs N/AAuto Tech. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Howard Lewis Wrightson, Sr. Evelyn G. Sullivan other traumatic and 2 should 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mrs. Helen Marie (nee Kesselring) Wrightson 3904 Nemo Road Randallstown, MD. 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel 1 Burial 2 Cremation 3 Removal from State Nov.21, 2009 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. A
2325 York Road Timonium, Maryland 21093 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Set and Death Physician/ disease or condition Medical Examiner resulting in death) ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on: g physician and as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 2 No ate has been signed by the page 2 should be detached 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes . Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes 2 s after death.

al Director: After this certificated in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred To the Hospital or Attending iniury work? 5 Pending Investigation Accident Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in an arrival and a state of the cause of examination and/or investigation in a state of the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and or investigation and or invest Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 BALTIMORE, MA 21204 DANIEUE DOGETHAN MO 32 Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ C. 2009 Goldie Weisbecker Р 9:15 November Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 8208 Longpoint Road Dundalk Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ulv 18,1919 West Virginia 1 M 2 X F Months Days Hours 217-09-6627 Director 90 July Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 8208 Longpoint Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married <u>و</u> Yes 2 **X**No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 years Payroll Clerk Wholesale Flooring Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Cosser Anna Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Barbara Bonincontri 8208 Longpoint Road, Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Noveliber 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 23, 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to Brill Alan **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? و ک Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law autopsy perform death? this certificate 2 No ☐ Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral ithin 24 hours after death.

o the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Geoglyling Nurse Practioner: To the best of my knowledge, death personal at the time, data and place, and due to the easist(s) and 29b. Signature nd title certifier License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3029 Dundalk Avenue, Dundalk, Maryland Kiumarce Kashi M.D., FACP 31. Date filed (Month, Day, Year) 32. Registrar's Signature MOV 24 2009 Registrar

DHMH 17 Rev 7/2009

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death Date Month 23, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Physician Nov. 6:50 Shirley Ruth Yoor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3134 Texas Avenue Baltimore Parkville 8. Date of Birth (Month, Day, Year)
Feb. 28,1936 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Mary land 1 M 2 DE 73 216-32-0145 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. In the Pages 1, the Page Baltimore 1 ☐Yes 2 No Director Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 United States 3134 Texas Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Henrietta Stohr ပ Henry John Lohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 Gunview Farm Court, Perry Hall, Maryland 21128 Joseph Yoor/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, 21. Signature of Funeral Service Licensee Alice Iser Inc. 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fram awserredu Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy forι Day Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 No □Yes P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No page 1 ☐ Yes 2 ☐ No 1 □ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \sum \) Nursing Home 1 Yes 2 No 5 Residence 6 □ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manuser of Death 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifler

31. Date filed (Month, Day,

d cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 1625 PM Medical (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** lemoria 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ballimore 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 ☐ Married or ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔏 No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Be Middle, Last မ and 2 should b Health and Mer tem 27 is mark 20b. Place of Disposition (Name of Department of H Important: If ite any injury or other Burial 2 Cremation 3 Removal from State 1 Burial 2 ☐ Cremation 3 ☐ r 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of E Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dis Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) <sup>£</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): as the burial-transit or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No completed filled in by the funeral director, page 2 should be detached for Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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Funeral Director		5. Social Security N 218-66-05 Usual Residence of	13	Sex 1□M 2X F	7. Age (In yrs. Ia 92	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Month, Da 06/08/1	917	9. Birth	pplace (State or Foreign untry) POLAND
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permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Well once.	ij	SEYMOUR I					•	COURT,		-		ip Gode)
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Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final n	a			cleroti	ic dis	ease	٠		Onset and Death
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Frank Allan Ade	

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State of Maryland / Department of Health and Mental Hygiene

IAIN Allah Acc		1- For State Registrar  Gratificate of Death	and Mentairiy		200	9 3766
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)		Date of Death     Month     November		3. Time of Death 0446 hrs
nedical Exami	ner	Frank Allan Ade  4a. Facility Name (if not institution, give street and number)  4b. City, Tow	vn, or Location of Death	November	4c. County of Death	04401113
			Frederick		Calvert	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	Year If Under 24Hrs.  Days Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign /1950	
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b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.			20613		USA	
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after d	by Ft		No specify:		specify: Wh	ite
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1218 lbe fill ental H nrked vent, t	Be	Leo Ade		Terre		
D 2. should and Me 7 is ma	٩	19a. Informant's Name/Relationship (Type, Print )  Ann Marie Ade/Spouse  15960 Cro				
and 2 sho fealth and tem 27 is traumati		20a. Method of Disposition 20b. Place of Disposition (Name			20c. Location - City or	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nont of Health and Mental Hygiene. ant: If item 27 is marked other than 'or other traumatic event, the Medical		1 X Burial 2 Cremation 3 X Removal from State crematory or other place)  St. Mary 's C	Cem. 11/	23/09	Herkimer,	NY
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≒xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				-
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	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
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Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d d				
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687 certific nding p	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specific	3 Ectopic pregna	incy	Month [	Day Year
Box 687  The death certifice  The attending For the attending For the as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	/)		1	
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Vital Rec ysiclan: The his certificate director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DO/	Other		Residence 6 Other	r:
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been selen by the funeral director, page 2 should		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c.	c. Injury at Work?	28d. Describe h	ow injury occurred	
tendi death. ttor: /	atio	2 Accident Investigation	1 Yes 2 V No			
Divisipital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		or Town, St		Frederick MD
lospits 4 hours 7 unera		29a. Certifier 4 Continue Physician To the heat of my knowledge death accurred at the fit				
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated.				
F \$ F S	Me	29b. Signature and title of certifier	icense number		29d. Date signed (Mo	
		maybe me me	D.C.M.E. 		November 7, 200	U9 
RW 20		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Margarita Korell MD. Assistant Medical Examiner 111 Penn Street</li> </ol>	et, Baltimore, MD	21201		
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	-, -			
Regis	trar	NUV 10 2009 Denus B. parks				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 37664 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Nettie Venable Bennett 2009 November 10:45 pM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Ye Mar. 31, Year) • 1917 Months Davs Hours 1 ☐ M 2 🛣 F 214-16-4531 92 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Dorchester Cambridge YTYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 525 Glenburn Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No white Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) line worker chemical 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Venable Nettie Mae Sellers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jewel Pitts 5321 Beaver Neck Road, Linkwood, MD daughter 21835 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 11/21/09 East New Market, MD of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomyopathy 54eas Due to (or as a consequence of). congestive Sequentially list conditions, if any, leading to ininitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence of) CATION APPROVED BY MEDICAL EXAMINER ancreati mass Due to (or as a consequence of) dementiz CERT egnancy 23d. Date of delivery 3 Ectopic pregnancy Fetal death Month Day Year of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

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for use

completely filled in by the funeral director, page 2 should be

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After 1

death.

24 hours after deatle Funeral Director:

within 2 To the F

The law requires that the death certificate be executed

Box 68760,

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Division of Vital Records,

Physician:

Hospital or Attending

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

7 is marked other traumatic event.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Pages 1 and 2 should be nent of Health and Mental

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical 2 Completed Be Certification: To

2

FEMALE: 8b. Was decedent pregnant in the past 12 months? 1  □ Yes 2  □ No 9  □ Unknown	23c. If yes, outcome of pr 1
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

11/11/09

and manner stated.

2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

25	. Was case examiner	referred to	medical
	1 Yes	2 🗌 No	
27	. Manner of	Death	

1 Natural

2 Accident

(Check only one)

3 Suicide

5 Pending investigation 6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred Naking to dining room

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide hesepeake Woods 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

28f. Location Street and Number or Vural Route Number, City or Town, State) 525 Glenburn

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bramble 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

5100 M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37665 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 7 2005 NO**VE**MBER :29 A HARRIET LOUISE BRIGHTWELL Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year Country)
Mary Land 1 🗆 M 2 😿 Months Days Hours Min. 219-14-7817 84 **Director** May 6. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c, City. Town or Location 10d. Inside City Limits Director Frederick Frederick Mary land 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 4 East Ninth Street 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 X Widowed 4 ☐ Divorced al Hygiene. I other than "natura went, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Gaver Harry Schmidt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Chestnut Street, Frederick, Maryland 21703 19a. Informant's Name/Relationship (Type, Print) Nancy Sowell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Mount Olivet Cemetery 20a. Method of Disposition November 20. 20c. Location - City or Town, State Department of Important: If it any injury or c 1 X Burial 2 Cremation 3 Removal from State 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 Signature of Funeral Serv M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardispulmonary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HAPOXEMIC Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit Physician/Medical signed by the ar Be Completed by

I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 page 2 completed filled in by the funeral director, within 24 hours a

Certificate: To

Medical

(Check

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Shoaib Ali, M.D.

NOV 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

cause. Enter Underlying Cause (Disease or iinjury that initiated events	CHF Exacerbation								
resulting in death) Last	Due to (or as a consequence of):								
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)  9 ☐ Unknown	23d. Date of delivery  Month Day Year							
Part II. <b>Other significant conditions</b> con	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown							
		24a. Was an autopsy performed? 1 ☐ Yes 2 ★ No   24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ★ No   1 ☐ Yes 2 ☐ No							
25. Was case referred to medical	26. Place of Death (Chec	ck only one)							
examiner? 1  Yes 2 No	ospital:	lome 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death  1   Natural  Colored Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?  M 1   Yes 2   No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
200 Cartifier 1 N Cartifying Bhyois	airry. To the heat of my knowledge, death accurred at the time, date and place a	and due to the cause(s) and manner as stated							

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0068977

29d. Date signed (Month, Day, Year)

11-17-00

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

400 West Seventh Street, Frederick, Maryland 21701

DHMH 17 Rev 7/2009

State

Registrar

Box 68760 Records, **Division of Vital** 

Baltimore, Maryland 21215-0036

State Registrar only one)

29b. Signature and title of certifier

KODALI 29449 Charlotte Hall Road, Charlotte Hall, MD 20622 RAO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

D67788

29d. Date signed (Month, Day, Year) 11.9.2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Novith 5, 2009 George Burke 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 12. 1 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 📆 💥 2 🗆 F 012 22 693B Director 928 Mass Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Prince George Clinton 1 Yes 2 XXVo 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5702 Plata Street 20735 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 XXes 2 □ No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 It Yes, Give Korean Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: White 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Safety Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Joseph Burke Edmae Perrault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5702 Plata Street, Clinton, MD Marjorie Burke (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐-Burial 2 XX remation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) ee Crematory Nov 7. 2009 Clinton, Maryland Signature of Juneral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHE DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 L 9 Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE CORONARY 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION ESSENTIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 10 Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cartifier D67788 thekere 11-6-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 5 10 0 0 0 0 1 7 29449 Charlotte Hall Road, Charlotte Hall, MD LEENA RAO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

0 2009

/Med Exami **Funeral** 

Physic

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the "hwitch Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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	1 - State Registrar	aryland / De		of Death			Reg. No.	009	37668			
ian	1. Decedent's Name (First, Middle, Last)  RA	GDASI	AN			2. Date of Dea	Day 7	Sear	3. Time of Death			
cal ner	4a. Facility Name (If not institution, give street and number,	)	4b. City, T	Town, or Location	of Death		4c. Cour	nty of Death	0.			
	Anne Arundel Medical Cente	r	Ann	apolis			Anne	e Aruno	101			
	5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthd	ay) If Under	1 Year   If Unde		8. Date of Birt (Month, Da		9. Birthp	lace (State or Foreign			
	579-18-4416 Usual Residence of Decedent	92 Yrs	. Months	Days Hours	Min.	August		Coun L7 Virg				
_	10a. State 10b. County	10c. City, Town or	Location					11	0d. Inside City Limits 1 ☐ Yes 2 No			
ecto	Maryland Anne Arundel	10 0:1:	Og. Citizen of What Country?									
ä	10e. Street and Number	10f. Zip Code					10g. Citizen d		try ?			
era	11.6 Polling House Road  11. Marital Status 12. Was Decedent	Ever in U.S. 1		776	rigin? (Spe	oify Ves or No.	14 B	USA lace - Americ	an Indian			
Completed by Funeral Director	Armed Forces  1 □ Never Married 2 □ Married 2 □ Married  1 □ Never Married 2 □ Marr	No	If Yes, speci	ent of Hispanic O ify Cuban, Mexica ☑Mo Specify		Rican, etc.)	Spec	lack, White, e	etc.			
leted	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual	l Occupation k done during mo e retired)	st of workir	ng	16b. Kind of	Business/Ind	lustry			
dmo	Elementary/Secondary (0-12) College (1-4or 12 th		ster Plu				P1um	bing				
Be C	17. Father's Name (First, Middle, Last)			18. Moth	ner's Name	(First, Middle,	Maiden Surn	ame)				
일	Harry M. Bagdasian			Ros	a Mat	inos						
ľ	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address	(Street and Numi	ber or Rura	al Route Numbe	er, City or Tou	ın, State, Zip	Code)			
	Margery K. Calhoun / Compar	nion 572	O North	Shore	Pkwy.	, Churc	hton,	MD 207	733			
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Discemetery, of MD Veter	crematory or oth	her place)	11-3-	2009		n-City or To enham,	wn, state Maryland			
	21. Signature of Puneral Service Licensee			Address of Faci	· Ge	orge P. d Rd	Kalas Edgewa	Funer	ral Home ID 21037			
	2973 Solomons Island Rd., Edgewater, MD 21037  29a. art 1. Eny the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death diseas or condition resulting in death)  a. Due to (or as a consequence of):											
	Im distributed (Final diseas or condition resulting in death)	Henr	Heelen	Onset and Death								
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Medical Examiner	resulting in death) Last Due to (or as	a consequence of):										
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Completed by Physician/M	IF FEMALE:     23b. Was decedent pregnant in the past 12 months?     1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal death 2 ☐ Company III ☐ Live birth 2 ☐ Fetal death 2 ☐ Company III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Fetal death 3 ☐ Ectopic pregnancy III ☐ Ectopic pregnancy III ☐ Ectopic pregnancy III ☐ Ectopic pregnancy III ☐ Ectopic pregnancy II											
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ed by	Part II. Other significant conditions contributing to death be	out not resuling in the	e underlying ca	use given in Part	I.		es 2 □ No		1			
plet						24a. Was autop		prior to cou	psy findings available appletion of cause of			
performed?   1   Yes 2   No   1   Yes 2   N								_				
Be	25. Was case referred to medical examiner?	*		T	e of Death	(Check only o	ne)					
မ	1 Yes 2 No Hospital: 1 Inpati					ome 5 Residence 6 Other (Specify)						
ion	27. Manner of Death  1 Natural  5 Pending (Month, Daily Control of the Control of	ury 28b. Time ay, Year) Injur	e of 28 ry M	3c. Injury at Work? 1 □ Yes 2 □		28d. Describe h	ow injury occ	urred				
Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Initial building, et	lury - At home, farm, c. (Specify)				28f. Location (S City or Tow	Street and Nur n, State)	nber or Rura	l Route Number,			
dical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner st	of examination and/o										
Me	29b. Signature and title of certifier		29c.	License number			29d. Date sign	ned (Month, i	Day, Year)			
	Amal) De	Mun		1)21	638		00	toher	29,2009			
	30. Name and address of person wing completed cause of a MicHARL J. Completed Cause of Complete Completed Cause of Cause of Ca	- un yu	oe, Print (1)Ef	ENSE	1/26	HWAY	ANNO	AROU.	MA2146/			
ate	31. Date filed (Month, Day, Year)  32. Redistr	rar's Signature	book	/								

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7, 2009 2020 November Thomas Jennings Bailey, III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Citizens Care and Rehabilitation Ct. Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Director 1933 Maryland 215-36-6675 March 16, 76 Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the "Molcal Examiner must be notified at 1X Yes 2 No Directo Frederick Frederick Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 21702 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the "Modes Examiner must any injury or other traumatic event, the "Modes Examiner must once." 1900 Rosemont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 5 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Attendant Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isabel Stedman Lamberton Thomas Jennings Bailey, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2704 Chestnut Grove Road Hazel La Coste / Friend Keedysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-10-2009 Frederick, Maryland Olivet Cemetery 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only obe Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1/20 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical /or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) JH-8 21701 300 W. Ninth St., Frederick, MD Robert L. Kaufmann 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me, 8897, 11/19/09/dhb

			1- State of Per Registrar Amend Item 26 per	Maryland / De verb., g897	pariment of Hea 11/12/09dhb ertificate of De			e2009	37670	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  EDW(N MALEOLW				10 2	6 2009	3. Time of Death 7, 25PM	
A.	Examir Funeral Director	ier	4a. Fecility Name (If not institution, give street and num Maryland Correctiona  5. Social Security Number  219-78-4565  6. Sex  219-78-4565		ay) If Under 1 Year If I	TOWN	Date of Birth	c. County of Death  UASITING  9. Birthp  County  Mary	ace (State or Foreign try)	
	g		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	r Location		17011		Od. Inside City Limits	
death with the Maryland	Ba-fet	ctor	MD Cecil	Cecil	ton				1 MgYes 2 □ No	
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. 0	citizen of What Coun	try?	
	eath v	erai	378 Wilson St.  11. Marital Status 12. Was Dece	edent Ever in U.S. 1	21913  3. Was Decedent of Hispar	nia Origin? (Specifi		S.A.	an Indian	
	172 hours after death with the Marylan *natural', or Items 23a or 28a-1 show olical Examinat must be notified at	by Funerai	1 Narrial Status  1 Naver Married 2 Married 1 Yes 1 Ves Married 2 Married 1 Yes, Gh Year or D	rces? 2 No	If Yes, specify Cuban, M	lexican, Puerto Ric	an, etc.)	Black, White,		
Maryland 21215-0036	be filed within 72 hours after tal Hygiene. d other than "natural", or Ite event, tra Medical Examira	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	-4or 5+) (G	ocedent's Usual Occupation ive kind of work done durin e. DO NOT use retired)	g most of working	16b.	Kind of Business/Inc	lustry	
2	fed w tygien har th		1 2 17. Father's Name (First, Middle, Last)	<u> P1</u>	ant Manage			g Farm		
anc		To Be	Marcus Arnold Carrol	l, Sr.		Mother's Name (Filamie Lo				
ary	should be ind Menta markad umatic ev	ř	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street and I				Code)	
	and 2 salth a n 27 lo		Christopher Rowe (	son) 57	Old Orcha	rd Dr.	Sickle	rville,	NJ 08081	
Baltimore,	Pages 1 ment of He ent: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	State cemetery, o	sposition (Name of crematory or other place)  remation	10/31		Location - City or To Iyrna , DI		
Balti	permit. Departn Importe any inju		21. Signature ( ) weral Service Licensee	M00510	22. Name and Address of Galena Fun 118 West C	eral Ho	me of S . Galen	tephen I	Schaech	
	Physician		231. Part1 Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final	ach line.	enter the mode of dying, su	uch as cardiac or re			Approximate Interval Between Onset and Death	
Examiner	/Medical Examiner	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of):  ALL Bo or as a consequence of):  CTAL	WEL DE	BSTRUC	TO NO	winter		
68760,	rificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last Due to (	or as a consequence of):		CERTIFICATION APPR				
	The law requires that the death certific lie has been signed by the attending p age 2 should be detached for use as I	Physician/Med	in the past 12 months?	ant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery Month Day Year		
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to de		Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
		Completed					24a. Was an autopsy performed? 1 ☐ Yes	prior to con death?	osy findings available inpletion of cause of 2 No	
on of Vil	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifica completely filled in by the funeral director.	tion: To Be	Catalulal S T Blomb	of Injury h, Day Year)  ER/Outpat  2 ER/Outpat  28b. Time	tient 3 DOA Other: 4		5 Residence			
Division of	al or Atten s after deat il Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be	of Injury - At home, farm, ng, etc. <i>(Specify)</i>			Location (Street: City or Town, Sta	ı (Street and Number or Rural Route Number, own, State)		
	he Hospil in 24 hour he Funers pletely fille	edical (	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medicel Examinar: On the band mann	best of my knowledge, deasts of examination and/or er stated.	eath occurred at the time, do	ate and place, and n, death occurred	due to the cause( at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)	
R	To the company	Σ	29b. Signature and title of certifier		29c. License nur			ate signed (Month, L		
			· Caroffee	MA	D522	274	18	)-26-	1009	
			30. Name and address of person who completed caus COUN OTTEM, MD	e of death (Item 23a) (Typ	DS27 POXBURY	ROAD	HASER	-STOUSH, n	1021740	
	Sta Registr	- 4	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>8</u> Mary I. Carter 2009 October 4:05 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heritage Harbour Health & Rehab Annapolis 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Jan 16 Year 928 Mary land 213-22-0065 81 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Millwood Rd. 21244 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 12th 0 Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Johnson Rebecca Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara C. Dickens(Daughter) 7406 Millwood Rd. Baltimore, Md. 21244 20a. Method of Disposition 20b. Place Diposition (dame of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park Park 11-2-09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M Manne Races Schi Sons Mortuary, 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of)

Priysician Medical Examiner

Physician/

Medical

10a, State

7406

Examiner

Funeral

Director

or 28a-f show notified at

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permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

the Medical

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Funeral

Completed by

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner sician and burial-transit by the attending physician tached for use as the buria by Physician/Medical been signed by the a should be detached Completed Be ျှ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate:

Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed

has

certificate

this

Division of Vital Records, P.O. Box 68760

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No g □ Unknown		ipic pregnancy er (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions  Dementure	contributing to death but not resulting in the underly	ring cause given in Part I.		use contribute to the cause of death?					
•			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  lo 1 □ Yes 2 ⅧNo					
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 Yes 2 KNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	6 ☐ Other (Specify)							
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation			8d. Describe how inju						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ctory, office 2		f. Location (Street and Number or Rural Route Number, City or Town, State)					
(Check 2 / Medical Exar	nysician: To the best of my knowledge, death occure miner: On the basis of examination and/or investigation are Practioner: To the best of my knowledge, death of	n, in my opinion, death occurred at t	he time, date and plac	e, and due to the cause(s) and manner stated					
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)					

Registrar

State

of death (Item 23a) (Type, Print)

		For	State of Mar	-	partment of H				
		State Registrar		С	ertificate of L	Death	R	eg. No. 200	37672
Physicia	an	1. Decedent's Name (First, Middle, L	ŕ				2. Date of Deat	Day Year	3. Time of Death
/Medic	al	Shirley		disman	4h Gib. Town on	Leastion of Dooth	Nov 09,	4c. County of Dea	12:26 P M
Examin	er	4a. Facility Name (If not institution, g		onitol		r Location of Death inton	1		George's
Funeral			Maryland Ho	SPITAL In yrs. last birthda	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Bi	rthplace (State or Foreign
Director		230 44 8214	<sup>1□ M 2</sup>	Yrs	Months Days	Hours Min.	March 2	9', 1937 Vi	rginia
pui 💌		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
f sho	ō			oc. Oity, Town of					1 □ Yes 2/ONO
the N	Director	Maryland Prince	George's		Clinton 10f. Zip Code		1	0g. Citizen of What C	1
3a or		10112 White Ave	9		207	'35		United S	tates
hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show at Evan and the motified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	Was Decedent of H     If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race - Am Black, Whi	
or it	by Ft	1 Never Married 2 Married	1 ∐Yes 2 <b>XX</b> Vo		1 □ Yes 2 □ vNo	Specify:		Specify:	White
hours tural		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's i	Year or Dates:	16a De	ecedent's Usual Occup	ation	- 1	16b. Kind of Business	
be filed within 72 ho ital Hygiene. d other than "natu event, he Medical	Completed	(Specify only highest g	rade completed)	(G	ive kind of work done of e. DO NOT use retired	during most of wor	king		•
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al Hy d othe	Be (	17. Father's Name (First, Middle, Las				18. Mother's Nan	ne (First, Middle, I	Maiden Surname)	
Meni Meni arkec	၉	Thurston H	owaysnerr	T			0	iehl	
2 sh h and r is m		19a. Informant's Name/Relationship			ailing Address (Street				Zip Code)
Healt Healt ther i		James W. Dadi	sman, Jr. (H					20c. Location - City o	r Town. State
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "in any injury or other traumatic event, the Medical Once.		1XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			sposition (Name of crematory or other place and Veteran			-	n, Maryland
mit. F partme oortan injur		21. Signature of Funeral Service Lice	0.000	riai y i c			-	Home, Inc.	·
any any		DODSecox (	mass	2	Alexandria			-	20735
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 5 2009 2:30a M Duff November Olivia 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 50 Brookside Place Charles Waldorf

with the Maryland

Baltimore, Maryland 21215-0036

1 - For State Registrar

Mozetta

**Physician** 

Examiner

**Funeral** Director

/Medical

Physician /Medi Examí

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

	5. 30ciai Security Number		1 □ M 2 □ F	9	7	Yrs.	Months Days	Hour	s Min.	DO.	onth, Day, Yea	016		intry)
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	21. Signature of Funeral			ma	109e2									ERAL HO
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	disease or condition resulting in death)	772	a				DIDLA	O.D.					-	
	Due to (or as a consequence of):  MYOCARDIAL INFARCTION													
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	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1	] Inpatient	2 🗆 ER/O	utpatient	3 □ DOA Ot	her: 4 [	Nursing H	lome {	5 ☐ Residence	6 ⊡oth		
	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury at Work?  28d. Describe how injury occurred Work?													
	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Investigation investiga									and Numberate)	er or Ru	ıral Route Number,		
	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.									anner as and due	s stated. to the cause(s)			
	29b. Signature and title of	of certifier	t				29c. Licen	se numb	27 ·	7	29d.	Date signed	(Month	h, Day, Year)
٠	30. Name and address of	of person w	ho completed car	use of deat	h (Item 23a)	(Type, F	Print)	c fi	<u></u>	~	10 3	-0(	54	6
	31. Date filed (Month, Da	ay, Year)	32.	Registrar's	Signature									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ronald Eugene Elwell 2009 November 1:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 11450 Asbury Circle, Apt. #433 Solomons Calvert Social Security Number 7. Age (In yrs, last birthday) 78 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours 215-28-4205 1 **X** M 2 □ F 06-05-193 Maryland Director Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director r 28a-f 1 ☐ Yes 2X No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or Funeral 11450 Asbury Circle, Apt. #433 20688 United States or items within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No 1954—
If Yes, Give 1067 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced 1967 Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MD Public Schools Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laura Elizabeth Osterhaus Ronald Arthur Elwell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Elwell (Wife) 11450 Asbury Circle, #443, Solomons, Maryland 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 o = 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 0 permit. Page Department o Important: If any injury or Metropolitan Crematory 11-10-09 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ arcinomo disease or condition resulting in death) ung Medical 6415 4montes Due to fir as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse ( 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Dav Pregnant at time of death 1 Yes 2 D signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been signature 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performe certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After **Natural** injury 5 Pending 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Aisompleted filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050686 November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+1 Gurdeep Chhabra, MD 23415 Three Notch Road, Hollywood, Maryland 20619

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV

32. Registra s Signature

2009▶

09-08698 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kimberly Dawn Edge State of Maryland / Department of Health and Mental Hygiene 37675 2009 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day November 8, 2009 1603 hrs Medical Examiner Kimberly Dawn Edge 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Dorchester Easton Momorial Hospital 6936 Reliance Road Federalsburg If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Country) Director April 29,1962 218-82-7227 47 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 X No Caroline Federalsburg or items 23a or 28a-f show must be notified at once. Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25612 Auction Road 21632 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 Married Yes 2 X No white Yes 2 X No specify: 4 Divorced If Yes, Give Yeer Specify Widowed ģ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than beauty shop beautician 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be William B. Edge Dorothy Airey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 9377 River Vista Drive, Seaford, DE Antonia DeGroat daughter If item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Important: If ite injury or other to crematory or other place) Bunal 2 XCremation 3 Removal from State 11/10/09 Crematory of Delmarva Delmar, DE Donation 5 Other Specify 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wounds (2) of Head taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED 4a, the attending physician led for use as the burial -UNPENDED 4b, & 28f, per ME g898 12/2/09 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available certificate has been sector, page 2 should 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be examiner? Other<sub>4</sub> Hospital: Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient 1 🗸 Yes မှ 28a. Date of Injury (Month, Day,Year) Unknown 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot self Unknown Natural 1 Yes 2 ✔ No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6936 Reliance Road 25612 Auction Rd., Federalsburg, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 V Suicide determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License numbe November 9, 2009 O.C.M.E

Registral
DHMH 17 Rev 1/2001
OCME 2006

State

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37676 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 13, 2009 **Physician** Helen C. Furstenberg 10:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7 Richard Way Allegany LaVale If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ F Yrs Oct 30, МD 215-20-7488 1926 Director 83 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Examiner must be notified at MD Allegany LaVale 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21502 USA 7 Richard Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo <u>۾</u> Specify: 3 Widowed 4 Divorced white natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be James T. Miller Ethel Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 John Furstenberg husband 7 Richard Way LaVale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ eremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2009 St. Mary's Cemetery MD Cumberland 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death). th death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ine. r complication. If at car's tonly one cause on Approximate Interval Between Onset and Death **Physician** Nemon /Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine or Attending Physiclan; The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 **1** No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Beath 28d. Describe how injury occurred 5 Pending 1 A Natural s after death.

I Director: A din by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a

To the Funeral I

completely filled filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. 20 states.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year)

7 State Registrar 29b. Signature and title of certified

23a) (Type, Print)

32. Registrar's

29c. License number

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 1 - State Registrar 37671 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ale 2009 Wayne Edward Flanagan 849 M October 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Memoria Year Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04/14/1938 Age (In yrs. last birthday) Sex 1 M 2 □ F Months Days Hours Min 219-26-5464 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2√⊡ No Maryland | Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Kerr Avenue 21629 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedo... Armed Forces? 1 □Yes 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. Flanagan/Son 4728 Idlewilde Road, Shady Side, Maryland 20764 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 💆 Cremation 3 Removal from State Kalas Crematory 10/29/2009 4 ☐ Donation 5 ☐ Oyner (Specify) Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. art1. E. or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or repair heart failure. List only one cause on each line. Immediate Cause (Final CARPIAC ARREST FLUTE disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 PER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

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Physician/Medical Completed

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Certification: To

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4 Homicide

29a, Certifier (Check only one)

sician and burial-transit attending physician for use as the buria signed by the a certificate funeral director, After this

Physician

Examiner

**Funeral** 

Director

28a-f show

Funeral Director

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f st amy injury or other fraumatic event, the Modical Evancians I was invalided and once.

**Physician** 

/Medical **Examiner** 

LANAGAD, WAYN

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital

death with the Maryland

/Medical

Hospital or Attending within 24 hours after death. To the Funeral Director: A filled in by the

> State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ENTUN MD 21629

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #31 State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 11/12/09 per VR Certificate of Death Reg. No. 37678 Reg. No 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ye ar Marquerite Ruth Fager /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fahrney Ready Home & Vilhor 5. Social Security Number 6. Sex 7. Age (In yrs. last thin Washing-bo 8. Date of Birth (Month, Day, **Funeral** (State or Foreign 1 □ M 2 🛛 F Months Hours Country) 196-14-0520 Director 86 08 02 1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Washington Boonsboro Director M∑Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Marguerite Ruth Fagers Baltimore, Maryland 21215-0036 8507 Mapleville Rd. 21713 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: white Specify: 3 Nidowed 4 Divorced alth and Mental Hygiene. 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental Clarence W. Fleagle J. Marie Utz ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Fager, III 22920 Midvale St. Hagerstown, MD 21742 permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Green Hill Cemetery 11/12/2009 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PA 17268 Lames 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carais rish disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): nam burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown Jarguerite Ruth Faces 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11-10-2045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 ofal Court Hazenstown MI Muhammed 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of p

32. Registrar's Signature

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death (Item 23a) (Type, Print)

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	Examin	er	4a. Facility Name (If not institution, give Julia Manor Nurs			Hagers	Location of Death		Washi		
-	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birti	hday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation				10d. Inside City Limits
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	th the	lrec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What	Country?
	23a o	Funeral Directo	11 S. Walnut Stre				217			USA	
	lteme Iteme	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W	merican Indian, 'hite, etc.
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	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or iteme 23a or 28a-f show any niury or other traumatic event, Ira Madical Examinar must be notified at ance.	Completed	15. Decedent's Ed	ucation de completed)	16a.	Decec (Give	lent's Usual Occupa	ation during most of work f)	tina	16b. Kind of Busine	ss/Industry
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<u> </u>	n: Th ficate nr, pag		05.116						1 ☐ Yes 2	2 1 □ Y	res 2□ No
5	s certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ER/Out	tnation	t 3 DOA Oth	26. Place of Deat		e ence 6 ∐Other(S	(nacihi)
5	g Phy ter thi	T :u	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. T	ime of	28c. Injun Work	y at		ow injury occurred	роспу
2	endin eath. or: Af	satic	1/☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1		.,,		Yes 2 □ No			
7	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	rm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
_	spital ours a neral i		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge	. death	occurred at the tin	ne, date and place.	and due to the ca	ause(s) and manner	r as stated.
	To the Hospital or Attending Physicien: The law requires that the death cer within 24 hours after death within 24 hours after death. To the Lonesti Directors Atter this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check drify 2 Medical Exam	niner: On the basis of e	examination and	d/or inv	estigation, in my o	pinion, death occur	red at the time, d	ate and place, and	due to the cause(s)
	To the within To the comp	N	29b. Signature and title of certifier	0. 1/4	0		29c. Licens	e number	2	9d. Date signed (Me	onth, Day, Year)
			Modale	gov m			000	4503		NOU !!	100-
A	H-1		30. Name and address of person who	completed cause of dea	ath (Item 23a) (	Туре,	Print)	and	etar	CSA H	200-8° teg MD 21740
	Sta	ite	31. Date filed (Month, Day, Year)	32. Ragistrar	's Signature						0
	Registr	ar	NOV 12 2	009 Densen	a 1.	1	and				

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

Baltimore MD 212P7

29d. Date signed (Month, Day, Year)

november 10, 2009

wolfe st.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vandana 600 Dalag

Year)V 32. Registrar's Signature 31. Date filed (Month, Day,

		for State Registrar	State of Ma	aryiano	Cer	tificate of E	ieaim Death	and M	епіаі ну	gien Reg. N		3 :	376	82
Physicia	n/	1. Decedent's Name (First, Middle, La	st)						2, Date of De		)av Year	3.	. Time of De	
Medic		Mary Jane Hudson							Novemb	$\overline{}$	200 <sup>9</sup>		3:07	A M
Examin	er	4a. Facility Name (if not institution, give				4b. City, Town, or	Location	of Death		4	c. County of Dea			
Funeral		11287 Tomahawk T  5. Social Security Number 6, S		e (In yrs. las	st birthdav)	Lusby If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Bir	th_	Calvert		e (State or Fe	oreian
Director		215-36-4640	□M 2 VF	70	Yrs.	Months Days	Hours	Min.	March March	y, Year	939 Wa	ountry) .shir	ngton,	DC
nd how at	J.	Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Loc	ation						10d.	Inside City L	imits
laryla 8a-f s tified	Director	Maryland Calvert		Lu	sby								1 🗆 Yes 2	X No
a or 2 be no	Ι	10e. Street and Number				10f. Zip Code				_	Citizen of What C	•		
h with	Funeral	11287 Tomahawk Tr				20657					nited St	ates	S	
r deat		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent E Armed Forces?		. 13. W	as Decedent of His Yes, specify Cubar	spanic O n, Mexica	rigin? (Spec an, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi		ndian,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	3   Widowed 4 □ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	NO	1	☐ Yes 2 🔀 No	Specif	y:			Specify: W	hite	9	
2 hour	Completed	15. Decedent's E (Specify only highest gr				ent's Usual Occupa		st of workin	ıa	16b.	Kind of Business	s Industr	ry	
ithin 7 ene. <b>than</b> <b>be Me</b>	Som	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DC	NOT use retired)	J				Janitor	ial		
Hygiw other ent, t	Be (	17. Father's Name (First, Middle, Last)			110 4 10		18. Mot	her's Name	(First, Middle,	Maidei				
d be fi	잍	Carrol Eugene Ne	wman						delyn l					
should and N is ma	7	19a. Informant's Name/Relationship (7	• • • • • • • • • • • • • • • • • • • •			g Address (Street a						ip Code	e)	
and 2 lealth sm 27 ther tr		Mary Louise Zelo	nis / Daug			Tomahaw	k Tr							
age 1 ant of h		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	Tmmac	metery, crem	ition (Name of atory or other place <b>CATT OT MAI</b>	) V	11/10/2	ate		Location - City o			
artme ortan injun		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Licen		Catho	lic Ceme	etery Name and Addres					rington			
Per Series		Thichael Keven	Hardenei S	h.		0. Box 6						- • •	••	
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused	the death.	. Do not ente	the mode of dying	g, such a	s cardiac or	respiratory ar	rest,			proximate erval Betwee	en.
Physician/		Immediate Cause (Final disease or condition	. Meta	Stat	ic !	oveast (	Caur	CEV	8				set and Dea	
Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):			1100200						
٠	Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	a conseque	ence of):							<del>                                     </del>		
d ansit	amir	Cause. Enter Underlying Cause (Disease or iinjury that initiated events			,							1		
exectian an	EX	resulting in death) Last	Due to (or as a	conseque	ence of):									
cate be executed physician and the burial-transit	ledical Examiner		I d									$\vdash$		
ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	icy						23d. Date of d	alivani		
eath c atten d for u	Completed by Physician/N	in the past 12 months?	1 Live Birth 4 Pregnant a		death 3 acth 5	Ectopic pregnancy Other (specify)	у				Month	Day	Year	
tached	Phys	g □ Unknown	9 Unknown											_
ss that igned be de	by I	Part II. Other significant conditions of				iderlying cause giv	en in Par	t I.			use contribute t			
require	etec	Coronary ar	per y ou	Lea	100				<b>}</b>		2 No 3 1			
e law e has b ge 2 s	ldmc	Type II Isralle	tes vuen	(17)					24a. Was auto perfo	psy ormed?	death?	comple	etion of caus	
an: Th tificate tor, pa	Be Co	25. Was case referred to medical				26. Pla	ice of De	ath (Check	1 Tes	2 🖽	4o 1 □ Y€	es 2	No	
nysicia iis cer direct	To B	examiner? 1  Yes 2 No	Hospital: 1  Inpatie	ent 2 🗆 E	R/Outpatient	Othe	r·			dence	6 ☐ Other (Spe	cify)		
ing Ph ifter th		27. Manner of Death 1   ↑ Natural 5 □ Pending	28a. Date of injur (Month, Day		28b. Time of injury	28c. Injury work		2	8d. Describe I	now inju	ıry occurred			_
ttend death stor: A	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of Inju	un. At hom	no form etro		Yes 2 L	$\overline{}$	196 I	24			- Al	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. fer death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled n by the funeral director, page 2 should be detached for use as the burial-transit		4 ☐ Homicide determined	building, etc	. (Specify)	ne, iariri, sue	er, ractory, office			City or Tov		nd Number or Ri e)	ıraı Hou	ite ivurnber,	
ospita hours uneral ed fille	Medical	29a. Certifier 1 Tertifying Phy	rsician: To the best of	my knowle	dge, death o	ocured at the time,	date and	place, and	due to the ca	use(s) a	and manner as si	tated.	and manna	- ototo
the H hin 24 the Fi	Med	or ly one) 3 _ Gertifying Nur	niner: On the basis of ex	best of my l	and/or investi knowledge d	eth occumed at the	time, del	te and plane	and due to the	e couse	(b) and trianner to	s stated.		stated
<b>5</b>		29b. Signature and title of certifier	1.			29c. License		2 26-		29d. D	ate signed (Mon	th, Day,	Year)	
\		30. Name and address of person who	completed called of d	eath (Item (	23a) (Tupo Pe		) c	735			11/6/0	7		
05		Catherine Brophy	(			er Blvd., S	Suite	203. I	Ounkirk	MD '	20754			
Stat		31. Date filed (Month, Day, Year)	32. Registra		ire					<u>, u</u>				
Registra	ir	NOV -	9 2009	ineur	, p.	parker								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physici /Medi Examir

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event; it we Medical Exeminer must be notified at agree.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	For State Of Mary 12	-	rtificate of L			Reg. No.	9 37683
an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
al		olets	1		October		4:30A M
er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
•	Casey House 5. Social Security Number 6. Sex 7. Age (In y.	rs. last birthday)	Rockvill	.e If Under 24 Hrs.	8. Date of Birt	Montgomen	rthplace (State or Foreign ountry)
	185-16-9749 1□M 2∏F 86	Yrs.	Months Days	Hours Min.	(Month, Da Dec. 18	1	
	Usual Residence of Decedent					1 72.2 12.011	, , , , , , , , , , , , , , , , , , , ,
_		City, Town or Lo					10d. Inside City Limits 1 X Yes 2 No
ectc		rest He				40	
al Dir	10e. Street and Number 121 Cree Drive		10f. Zip Code 20745			10g. Citizen of What C	ountry?
ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Race - Am Black, Whi	
Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	,		nite
eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa	ation Juring most of worki	na i	16b. Kind of Business	s/Industry
Jd III	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired  Secretai			Disabled A	merican Vet's
ပ္ပ	17. Father's Name (First, Middle, Last)	Lega.	1 Secretai	- y 18. Mother's Name			nerican vec s
Be c	Andrew Paul Slabey			Mary Ba	,	marcon damano,	
P	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a			er, City or Town, State,	Zip Code)
	George C. Holets/Son		Linn St. I				
			osition (Name of matory or other place	e) 10/21	)ate	20c. Location - City o	
	4 □ Donation 5 □ Other (Specify)	alas Cr		10/31		Edgewater,	•
	21. Signature of Funeral Service Licensee					Kalas Fune 11, Md. 20	
HS.	23a. art . Enter the disease or complications that caused the deshock, or heart failure. List only one chuse on each line.	ath. Do not en	nter the mode of dyin	g, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between
	Lance Park Course (Final)	Syndroi					Onset and Death
	resulting in death)  a. Due to (or as a cons						
L	Sequentially list conditions.		tic-stenos	sis			
ine	Sequentially list conditions, if any locaring to immediate cause. Enter Underlying						
xan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons		pertension	1			
alE							
edic	0.						
M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F.		Ectopic pregnancy	,		23d. Date of d	elivery
sicia	1 Yes 2 No 4 Pregnant at time of		Other (specify)			Month	Day Year
Phy	9 Unknown		and a state of the	on in Cont.	non Did.	ohaga usa sastitut	to the cause of death?
by	Part II. Other significant conditions contributing to death but not ratrial fibrillation	esuiting in the t	unaeriying cause give	en in Part I.		obacco use contribute	to the cause of death?  Probably 4 ☑ Unknown
eted							
Completed by Physician/Medical Examiner	-				24a. Was autor perfo	osv prior to	autopsy findings available o completion of cause of
ပ္ပ	25. Was case referred to medical			26. Place of Death			s 2 No
o Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2	☐ EB/Outpatie	ent 3 DOA Othe			dence 6 MOther (Sp	necify) II
n:T	27. Manner of Death 28a. Date of Injury	28b. Time o		/ at	28d. Describe I	how injury occurred	nospice -
atio	2 Accident investigation	) Injury		Yes 2 □No			
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - Al building, etc. (Spe	home, farm, st	treet, factory, office		28f. Location (3 City or Tox	Street and Number or I vn, State)	Rural Route Number,
S E	29a. Certifier 1 ☑ Certifying Physician: To the best of my	knowledge, dea	th occurred at the tir	ne, date and place	and due to the	cause(s) and manner	as stated.
edica	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	ination and/or it	nvestigation, in my o	pinion, death occur	red at the time,	date and place, and do	ue to the cause(s)
Σ	29b. Signature and title of certifier  T. Ko wakeho u, m	0	29c. License	63748		29d. Date signed (Mor Oct. 30, 2	
	30. Name and address of person who completed cause of death (I	tem 23a) (Type,					
	Jocelyne Kouatchou, M.D. 6001  31. Date filed (Month, Day, Year)  32. Pegistrar's Signary	anaturo		Rd. Rockv	ille, M	ID. 20855	
te ar	OCT 3 0 2009	B. A	backer				

0 Sta

		Please	Type or Prir					-		•	
		For State Registrar	State of Ma	aryland		artment of <i>rtificate o</i>	Health and I f Death	Mental Hy	/giene Reg. No		37684
Physicia	n	1. Decedent's Name (First, Middle, La						2. Date of Do	eath Da	, 20°0°9	3. Time of Death 9:45 P M
/Medic	al	Arthur Her  4a. Facility Name (If not institution, gi			-	4b City Town	, or Location of Death			County of Deatl	
Examin	er	Northampton	,				lerick			Frederi	
Funeral Director		5. Social Security Number 6. 5 167–20–6345	Sex 12X M 2□ F 83		ast birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Nov 8	ay, Year)	Co	hplace <i>(State or Foreign</i> untry) nsylvania
land ow t		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
burs after death with the Marylan ral", or items 23a or 28a-f show	ţo	Maryland Frede	rick		IIni	on Brid	ge.				1 □Yes 2 🛣 No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?
sath w	Funeral	10023 Green Vall	ey Road	Ever in II 9	2 12		21791	necify Ves or N		ited Sta	
ifter de		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces? 1 □ X7 es 2 □ N	No			f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)	0-	Black, White	
ours a	d b	3 Widowed 4 □ Divorced	Year or Dates:	WWII		1∐Yes 2∭XN				Specify:	White
in 72 h	olete	15. Decedent's E (Specify only highest gr	ade completed)	ļ,	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of wor.	king	16b. K	ind of Business/l	ndustry
filled within 72 hours after death with the Maryland Hygiene. When than "natural", or items 23a or 28a-f show out, the Medical Examination must be multified.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Veter	inarian			S	mall An	imals
be file nta! Hy id othe event,	Be	17. Father's Name (First, Middle, Last	,				18. Mother's Nan	, ,		Surname)	
hould id Mer marke matic	ည	Saul Herrin 19a. Informant's Name/Relationship			19h Mailie	na Address (Stra	Don tet and Number or Ru	othy Go		or Town State 7	Zin Code)
nd 2 s alth ar 27 is er trau		Jeanne Herring /			I .		Valley Rd.				
es 1 a of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Ramoval from State	20b. Pl	lace of Dispo emetery, crei	esition (Name of matory or other p	lace)	Date		ocation - City or	
t. Pag rtment rtant; rjury c		4 Donation 5 Other (Speci	fy)	Sta		Cremato		/2009		rederick Funeral	k, Maryland
print. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagores.		21. Signature of Funeral Service Lice	nsee	10-	22	2. Name and Add	dress of Facility Opossumtow				
		23a. art1. Enter the dise se or con	rplications that period	the death	. Do not en		-			Í	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	one cause on macrim	eme	entra					1	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						
	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):					-	
executed in and ial-transit	Examiner	that initiated events	c								
bricia be		resulting in death) Last	Due to (or as	a consequ	ence of):						
tificate ig phys as the	edic		_ d								
tth cer ttendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregna	ancy		15	23d. Date of deli	ivery Day Year
e law requires that the death cer has been signed by the attending 2 should be detached for use	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	eath 5	Other (specify)				Wichti	Day Tour
s that gned b	by Ph	Part II. Other significant conditions	contributing to death br	ut not resu	lting in the u	nderlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
een si		greeseer	decomp	enso	inor			1 🗆	Yes 2	□ No 3□ Pr	robably 4 Unknown
The law requires that the death certificate rate has been signed by the attending physpage 2 should be detached for use as the	ompleted	Perpheral	Vaseula		aire	are		24a. Wa: auto peri	opsy ormed2/	prior to o	topsy findings available completion of cause of
iclan: The certificate ector, pag	Be Co	25. Was case referred to medical	<u></u>				26. Place of Dea	1 □ Yes ath (Check only		1 □ Yes	2 🗖 No
hysic this ce al direc	은	examiner? 1 Yes 2 No				IL 3 LI DOA		lome 5 🗆 Res	idence	6 ☐Other (Spec	cify)
To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Date	ry y, Year)	28b. Time o Injury		njury at /ork? □Yes 2□No	28d. Describe	how inju	ry occurred	
r Atten er deal rector by the	tifica	3 Suicide 6 Could not be determined	oe One Diago of Init	ury - At ho	me, farm, str	eet, factory, offic	e	28f. Location City or To	(Street ar	nd Number or Ru	ural Route Number,
pital o	Ser	29a. Certifier 1 Certifying P	hysician: To the best	of my know	wledge deat	h occurred at the	a time date and place	and due to th	e cause/s	and manner as	s stated
he Hos in 24 h he Fun pletely	edical		miner: On the basis of and manner sta	f examinat							
To th To th Com	Σ	29b. Signature and title of certifier	Horn m	D -		29c. Lice	ense number		29d. Da	ate signed (Month	
		30. Name and address of person who	Completed cause of d	eath /item	23a) (Tune		3/636			11/05/	2009
Otl		Syled Haque	700 m	200	italo	line P	we Fre	deric	KI	1D 2	1701
Stat Registra		31. Date filed (Month, Day, Year)	6 2009 Registr	ar's Signat	ure A.	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2

DHMH 17 Rev 1/2001

**ORIGINAL** 

09-08233 Laura H Hess Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ira n ness		State of Maryland / Department of H 1-For State Certificate of D Registrar		Reg. No.	2009 3768
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day October 23, 2009	3. Time of Death Year 1135 hrs
CUICAI EXAIIII	1161	Laura Hughlett Hess  4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Dear		unty of Death
			Hunt Valley		more County
Funeral Director		170-54-0031 <sub>1 M 2 X F</sub> 47 <sub>Yrs.</sub>	If Under 1 Year If Under 24Hi Months Days Hours Mi		9. Birthplace (State or Foreign PA Country)
d 10w any		Usual Residence of Decedent  10a. State			10d. Inside City Limits  1 Yes 2 No
ne Marylan or 28a-f sl	Director	10e. Street and Number 203 Koser Rd.	0f. Zip Code 17543	10g. Citizen	of What Country?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, 1 Yes 2 X No	Decedent of Hispanic Origin? (specify Cuban, Mexican, Puer es 2 No specify:	to Rican, etc.)	Race - American Indian, Black, White, etc. white
72 hours afl "natural" al Examins	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Company On	Usual Occupation (Give kind of of working life, DO NOT use re	f work done 16b. Kind atired)	of Business/Industry
0036 within iene. ner that	dmc	12 Owner-Op		ne (First, Middle, Maiden Sur	
215-1 e filed tal Hyg ked oth	Be C	17. Father's Name (First, Middle, Last)  John Hughlett		y S. Keer	name)
21; hould b ad Men is mar	To	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ddress (Street and Number o		r Town, State, Zip Code)
and 2 sl ealth ar lem 27 traums			ser Rd. Lititz	D-1-2000 1000 100	ation - City or Town, State
Limore Pages I ment of H tant: If it		4 Donation 5 Other Specify:	on (Name of cemetery, place) Services mation	t. 27, Leo	la, PA
Ball permit Depar Impo		22. Name of Funeral Service Licensee 22. Name of Superal Service 22. Name of	ne and Address of Facility S. Broad St.	pacht Funeral Lititz, PA 17	Home, Ltd.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest, shock,	or heart Approximate Interval Between Onset and
≺/Medical kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxication  Due to (or as a consequence of):			Death
	_	Sequentially list conditions, b			
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
cuted nd transit		events resulting in death) Last  Due to (or as a consequence of):  d.			
be exection a sician a urial - 1	Medical	AMENDED 23a,27,28a-f,per	ME, g898 12/2,	/09 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after the Attential Physician. The law requires that the death certificate because of the Funeral Directora. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1	death 3 Ectopic preg	23d. E	Date of delivery Onth Day Year
). Bc the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
P.C.	d by			1 Yes 2 🗸 N	lo 3 Probably 4 Unknown
ords w requi	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Rec The la Tate h	Com		•	1 ✔ Yes 2 No	1 Yes 2 No
ital sician: s certif irector,	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Che  3 DOA Other		e 6 V Other: Scene
of V ng Phys neral d	): To	1 V Yes 2 No 1 Imparent 2 Errocupation 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	ury 28c. Injury at Work?	28d. Describe how injury	occurred
ion ttendir feath. tor: A	atio	Natural 5 Pending Fd 10/23/09 Fd 1:07		subject ing	ested drugs
Divis tal or A rs after or al Direct	Certification:	3 X Suicide 6 Could not be determined (Specify) hote1	factory, office building, etc.	or Town, State) 22 Circle Hunt	Number or Rural Route Number, City 1 International Valley, MD
Division of Vital Records, To the Hospiral or Attending Physician: The law required to the Funeral Birector: After this certificate has been completely filled in by the funeral director, page 2 should	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, date and place, a	and due to the cause(s) and r	manner as steted.
To To Com	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Da	ite signed (Month, Day, Year)
		Maryon melferill	O.C.M.E.	Octob	per 24, 2009
_		Name and address of person who completed cause of death (Item 23a)     Margarita Korell MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, M	D 21201	
<u> </u>	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	trar	NOV 2 4 2009 Genera B. gara			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3 John David Kaleo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth **Funeral** 04/01/1938 1 🔀 M 2 🗆 F Days Min Hours 215-34-9384 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Davidsonville MD Anne Arundel 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 3899 Greenmeadow Lane 21035 USA and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner ned Forces? Black, White, etc. ö ģ 1 Never Married 2 Married X Yes If Yes, Give Year or Dates. 1957-63 1 ☐ Yes 2 K No Specify: "natural", Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Construction General Contractor permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, I Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Kuononi Kaleo Nancy Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine D. Kaleo/Spouse P.O. Box 354, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Oremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lakemont Mem. Gardens 11/07/2009 Davidsonville, Maryland Signature 22. Name and Address of Facility Funeral Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LOW Immediate Cause (Final Physician/ card 10 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1529Se Stage Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has eral Director: After this certificate I filled in by the funeral director, pag 2 1 Yes 2 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 Inpatient 2 -ER/Qutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature, and title of certifie 20d, Date signed (Month, Day, Year) 2009 Hospital 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Jeovae 31. Date filed (Month, Day, Year)

9

6

M

09-08902 Lina Koontz

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ina Koontz	State of Maryland / Department 1- For State Certification	nt of Health and Mental H te of Death	200	0 2768
Physician/	Registrar	0.000	Reg. No.  2. Date of Death  Month Day Year	3. Time of Death
Medical Examine			November 16, 2009	1134 hrs
	Facility Name (if not institution, give street and number)     Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		1 0	thplace (State or Foreign buntry)
Director	212-58-9985 <sub>1 M 2x</sub> 56	Yrs. Months Days Hours Min		aryland
è	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
in in in	Maryland Washington Wil	liamsport		1 Yes 2 X No
the Maryland a or 28a-f sh tifted at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f show any notified at once.	14702 Clear Spring Road	21795	USA	
r death with or items 23	11. Marital Status 1 Never Married 2 X Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>		ican Indian, Black,
ter dea	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: W	hite
ours aft atural' xantine	Lor Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation (Give kind of iring most of working life, DO NOT use ret		Industry
136 thin 72 hours after than "natural edical Examin	Elementary/Secondary (0-12)	accounting clerk	medical	center
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
215 be file ntal Hy rked o	Abram Horst	Lina R	uth Horst	
Should and Me is mail		Mailing Address (Street and Number or		
and 2 sho ealth and tem 27 is traumati		4702 Clear Spring R Disposition (Name of cemetery,	Date 20c. Location - City o	
Baltimore, MD 2121; permit. Pages I and 2 should be fil Department of Health and Mental I Important: If iten 27 is marked injury or other traumatic event,	Codor	y or other place) Lawn Mem. Park   11,	/21/09 Hagersto	wn, Maryland
Baltin permit. P Departme Importar injury or	4 Donation 5 Other Specify: CEUGL 21. Signature of Funera Service License		INNICH FUNERAL HO	
	COUT! / Januar		., Hagerstown, Md.	
Physician /Medical	23a. Part I. Enter the disease, of complications that caused the death. Do not failure. List only one cause on each line.			Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic  Due to (or as a consequence of):	cardiovascular dis	ease	20001
	Sequentially list conditions, b			_
arine eri	if any, leading to immediate cause. Enter brunenying Cause (Disease or injury that initiated			16
led Insit	events resulting in death) Last Due to (or as a consequence of):			
execu an and al - tra	X UNPENDED AMENDED OF THE OTHER	7 000 0/1/10	mm	<u> </u>
	IF FEMALE: 23c. If yes, outcome of pregnancy	perm.E g900 2/1/10	23d. Date of delive	
Box 6876 e death certificate the attending phy ed for use as the I	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn  Other (Specify)	ancy Month	Day Year
). Box 6876 the death certificate by the attending phy ched for use as the Physician/M	1 Yes 2 No 9 Unknown g Unknown	Silling of the Control of the Contro		
		in the underlying cause given in Part I.	23e. Did tobacco use contribute t	
Records, P.C The law requires that ficate has been signed ; page 2 should be det	Diabetes mellitus	-	24a. Was an   24b. Were a	utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should in partification: To Be Completes.			performed? death?	completion of cause of
Vital Rec ysician: The his certificate director, page		26.Place of Death (Check		2 140
Vital Vital hysicians this certi	1 Yes 2 No 1 Inpatient 2 V ER/Out		ng Home 5 Residence 6 Oth	er:
ding Phy. After the function of Y	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	me of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
	2 Accident Investigation 28e. Place of Injury - At home, far	m, street, factory, office building, etc.	28f. Location (Street and Number or F	Rural Route Number, City
Division ospital or Attending tours after death. neral Director: After filled in by the function.	3 Suicide 6 Could not be determined (Specify)	,, ,,	or Town, State)	
To the Hos within 24 h To the Fun completely	one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b Signature and title of gertifier	/estigation, in my opinion, death occurred	at the time, date and place, and due to	
	2 Say Significant and the Or vertilled	O.C.M.E.	November 17, 2	
	30. Name and address of person who completed cause of death (Item 23a)			
	Laron Locke MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21	201	
Stat Registra				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOT. Charles H. Kenton 01, 2009 0835 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing & Rehab Ctr. Denton Caroline 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 🕱 M 2 🗆 F 218-07-8883 89 May 1, Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2968 Hunting Creek Road 21655 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 ∏XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lifelong Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Virgil Kenton Matilda Lubba 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2990 Hunting Creek Rd., Preston, MD 21655 John Alan Kenton/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Junior Order Cem. 11/06/09 Preston, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) asziration Susmanic Due to (or as a consequence of): embolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): atrial fibrillation Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardionyopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autoosy perform 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hygiene.

In portant: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at one.

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

requires that the death certificate be

Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical ģ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CM

29c. License number 0002392

Porston MD

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

But Lednum Ave 136

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Marylar					and M	lental Hy	giene				
			State Registrar	()		Cer	tificat	e of D	eath			Reg. No	200	19	376	90
	ysicia Medic		1. Decedent's Name (First, Middle, La Irving C. Linto	<i>'</i>							2. Date of De Month 11-1		) 09	'ear	3. Time of Di 12:35	eath A <sup>M</sup>
	kamin		4a. Facility Name (if not institution, give		r)			Town, or		of Death			. County of Frede			
Fur	neral		College View Co		Age (In yrs. I	ast birthday)	If Unde	ederi r 1 Year	If Under		8. Date of Bir			9. Birthpl	ace (State or F	Foreign
	ector		216-14-5939	<b>X</b> M 2 □ F	91	Yrs.	Months	Days	Hours	Min.	4-24-1	918		Counti	y) MD	
bud	at	or	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Loc	ation							10	d. Inside City	Limits
Maryla 28a-f	otified	Director	MD Frederic	k	Ij	jamsvil	le								1 🗆 Yes 2	2 X No
th the	t be n		10e. Street and Number	1 D 1				754					izen of Wh	at Count	ry?	
eath wi	r mus	Funeral	9537 Fingerboard	12. Was Decede		S. 13. V	Vas Dece	dent of His	spanic Or	igin? (Spe	ecify Yes or No-		14. Race -	America	ın Indian,	
<b>21215-0036</b> within 72 hours after death with the Maryland gjene. than "natural", or items 23a or 28a-f sho	amine	by	1 Never Married 2 Married	Armed Force 1 Yes 2 If Yes, Give	☐ No			city Cubar 2 🕱 No			Rican, etc.)			White, e		
hours a	ical Ex	letec	3 Widowed 4 Divorced	Year or Dates Education	s. WWII	16a. Deced	ent's Usu	al Occupa	ition				ind of Busi	Whit		
21215-0036 within 72 hours after giene.	e Med	Completed	(Specify only highest g Elementary/Seconday (0-12)	rade completed)  College (1-4	or 5+)	life. DO	O NOT us		uring mos	st of worki	ing					
nd 21 filed with	int, the	Be C	Ukn 17. Father's Name (First, Middle, Last)	• 111			Pavi	ng T	18 Moth	ner's Name	e (First, Middle,		struc	CLIO	n	
Maryland 2 should be filed Ifth and Mental Hy 77 is marked oth	traumatic event, the Medical Examiner must be notified at	To	Thomas F. Linton	ì							. Mille		camamoy			
Maryl should and Me	rauma	3	19a. Informant's Name/Relationship (				_				l Route Numbe					
_ =	other t	. 1	Ronald Linton  20a. Method of Disposition	S	on 20b. F	Place of Dispos	sition (Na	ne of	- :		rpers I		ocation - Ci			
Page 1	iry or		1 X Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		aic	cemetery, crem Lon Cha			9)	11-2	1-2009			-		and
Baltimore, permit. Page 1 and Department of Hea	any injury or		21. Signature of Funeral Service Licer	39		22	. Name ar	nd Addres		<sup>ity</sup> Ke	eney &	Basf	ord I	.A.	F.H.	
	. 10 01	_	23a. Part J. Enter the disease, or con	polications that cau	MO117						eet Fre		ick, I	<u>10 2</u>	1/01 Approximate	
Physic	cian/	6 6	shock, or heart failure. List only Immediate Cause (Final Bease or condition	one cause on each	line.						in 1		ast.		Interval Between Onset and De	eath
Med Exam	dical niner		resulting in death)	a. Due to (or	as a conseq		0								V	<i>y</i>
a lead	TA P	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for	ಷತಿ ಷ ಕರ್ವಾಕಿಂಭ	dente oij.										
) scuted	transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of:								+		
Records, P.O. Box 68760  The law requires that the death certificate be executed ate has been signed by the attending physician and	rector, page 2 should be detached for use as the burial-transit	edical E	resulting in death) Last	I d	as a conseq	action oil.										
68760 sertificate b nding physi	as the		IF FEMALE:	u			_									
Box 6 death cer	for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live Bir 4 ☐ Pregnar	th 2 🗌 Feta	aldeath 3 🗌	Ectopic Other (s		/				23d. Date Month		ry Day Yea	ar
the deay	ached	hysi	1 Yes 2 No 9 Unknown	9 Unknov		aoa o =	-									
, <b>P.O.</b> ss that the	be det	q	Part II. Other significant conditions	contributing to deat	th but not res	sulting in the u	nderlying	cause giv	en in Parl	i.					e cause of dea ably 4 🗌 Un	
ords requir been s	should	letec									24a. Was				sy findings ava	
Vital Records, sysician: The law requires is certificate has been significate bas bas bas bas bas bas bas bas bas bas	age 2	Completed									auto	psy ormed?	prid	or to con ath? Yes	pletion of cau	ise of
tal F cian: T ertifica	ector, p	Be	25. Was case referred to medical examiner?	Hospital:						ath (Check	only one)	2 111	J			
Physi rthis o	ral dire	÷ 10	1 Yes 2 No 27. Manner of Death	1 L Inp	injury	ER/Outpatien 28b. Time of		OA Othe	4 6		me 5 Resi			Specify)		
On C anding sath.	ne fune	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month,	Day, Year)	injury	м	work	Yes 2	_		now myan	, 000000			
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	et, factor	y, office			28f. Location ( City or Tox			or Rural i	Route Number,	s
D spital hours	d filled	Medical	29a. Certifier 1 Certifying Ph													
the Ho hin 24 the Fu	nplete	Mec	(Check 2   Medical Exan only one) 3   Certhying Nu				leath occu	rred at the	time, dat			ne cause(s	and mann	er as sta	ted.	er stated.
o ş t	8 8		29b. Signature and title of confifer	M		10,0	.   29	c. License	number	19	9		te signed (A			
,			30. Name and address of person who				rint)								/	
	Q.		Dr. Ronald F. Mi 31. Date filed (Month, Day, Year)	11er MD 4	-Culw	ell-Dri	iye M	<u>lount</u>	Air	y MD	21771					
Re	Stat aistra		on Date in Month, Day, Team 3	Certain 199	strair Signa	The state of the s										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	ate of Maryland	l / Depa	rtment of F	lealth and Death	Mental Hy	giene 2 (	009	37691
	Physicia	n/	Decedent's Name (First, Middle, Last)	( ) I	111			2. Date of De	ath	Year	3. Time of Death
	Medic	al	Leatha Jane Lowell  4a. Facility Name (If not institution, give street	(AKA Lea L	owerr)		Landing of Dark	Octobe		2009	5:20 A M
	Examin	er	Sanctuary of the Ho			4b. City, Town, or Burt	onsville		4c. Cour	nty of Death Monto	gomery
ı	Funeral Director		5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs. last	t <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year) <b>4, 1</b> 931	9. Birthp Coun	place (State or Foreign htry) Idaho
	tand show dat	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Arune		Town or Loc	ation Sever				1	10d. Inside City Limits
	he Mary or 28a-1 e notifie	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	1 Yes 2XXNo
	th with t ns 23a must b	neral	504 Grainfield Cou		Lean		21144			U.S	
920	rs after dea ıral", or iter Examiner		1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces?  Yes 25 No Yes, Give ear or Dates.	If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔼 No	n, Mexican, Puer			ace - Americ lack, White, ify: W	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show anmatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Educatie (Specify only highest grade co Elementary/Seconday (0-12)		(Give k	ent's Usual Occupa ind of work done of NOT use retired) Chef	ation Juring most of wo	rking		Business Inc	dustry Ompany
land 2	should be filed w and Mental Hygi is marked othe raumatic event, i	To Be	17. Father's Name (First, Middle, Last)  Clarence J. Rynea:					me (First, Middle, Mae Gif		me)	
	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Pi Kathleen Harkness-Jo			g Address (Street a Grainfiel					Code) 21144
Baltimore,	Page 1 an пелt of He <b>ant: If iten</b> <b>ury or oth</b>		20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cer	netery, crem	sition (Name of atory or other place Cremato		Date /4/2009	20c. Locatio	•	own, State Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Si n. l. rieral Selvice Acense	dille		Name and Addres					1 Home , MD 21401
٦			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caule immediate Cause (Final	se on each line.							Approximate Interval Between Onset and Death
	Pnysician/ Medical		disease or condition resulting in death)	Sepsis  Due to (or as a consequent	nce of):					-	
	Examiner	<u>-</u>	Sequentially list conditions, b. —	Sacral De		ıs Ulcer				_	
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence Cerebrova		n Disease	4.9			- 4	
	execut ian and irial-trar	l Exa	that initiated events c. — resulting in death) Last	Due to (or as a conseque							
200	physici the bu	edical	d								
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	yes, outcome of pregnand Live Birth 2 Fetal o Pregnant at time of de Unknown	death 3 🗌	Ectopic pregnand Other (specify)	у			Date of deliv	rery Day Year
s, P.O.	res that the signed by d be detac	ğ	Part II. Other significant conditions contribu	iting to death but not resul	ting in the ur	nderlying cause giv	en in Part I.	23e. Did1			he cause of death?
Division of Vital Records,	he law requ te has been age 2 shoul	Completed						24a. Was auto perf	an 24l psy ormed? 2 X No	b. Were auto prior to co death?	opsy findings available ompletion of cause of
Ea F	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?				ace of Death (Che		Z ZX NOT	103	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Ž	Physician: 1 r this certifica ral director, p	မ	1 Yes 2 No Hospi  27. Manner of Death	1 Inpatient 2 E	R/Outpatien	t 3 DOA Othe	4 tyly Vursing	Home 5 Resi	dence 6 🗆 O		)
o uc	nding ath. r. After ie fune	icate	1XXNatural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	work	? Yes 2 🗆 No	Zou. Describe	now injury occi	ined	
Division	al or Atte s after de l Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location ( City or To		nber or Rura	l Route Number,
_	ne Hospitt n 24 hours ne Funera	Medical	29a. Certifier (Check only one) 3 Certifying Physician (Check only one) 3 Certifying Nurse Pra	To the best of my knowled in the basis of examination a ctioner: To the best of my knowledge.	and/or invest	igation, in my opinio	n, death occurred	at the time, date	and place, and	due to the ca	use(s) and manner stated.
	To the within commendation		29b. Signature and title of certife	2 Mp		29c. License	number 053337		29d. Date sign		Day, Year) , 2009
7	42		30. Name and address of person who comple Dorothy Seay, MD 2	eted cause of death (Item 2 5 Main Stree			Reisters	stown, M	aryland	1 211:	<del></del> 36
	Sta Registra		31. Date filed (Month, Day, Year) NOV 05 2009	32. Pégistrar's Signatur	re. 19.	ares					
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DHMH 17 Rev 7/2009

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OCMF 2006

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 16, 2009

Tag

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrar's Signature

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Mostlanday

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 05

Agne

Mckenzie,

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MARTELL 0450 M USAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 17, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) - 1945 **Funeral** Months Days Hours 1 M 2 Z F 021-34-5620 64 Director Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10c. City. Town or Location 10d. Inside City Limits 10a, State 28a-f show other traumatic event, the Wedical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2X No Shady Side MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 20764 **USA** 1737 Maryland Ave. or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ M∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify. 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ntal if Health and Menta item 27 is marked Anne Elizabeth Gookins Harold J. Halloran 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Martell / spouse 1737 Maryland Ave. Shady Side, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 11/2/2009 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or comunications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only cover cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ned by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2/ No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License numbe Mo completed cause of death (Item 23a) (Type, Print) 4 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

# Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 32 PM 10 2009 Nov. Christian Andrew MILLER, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 115 N. Cleveland Avenue Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Director 214-48-2724 62 July 29 1947 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov 1 Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or: by Funeral <u>21740</u> 115 N. Cleveland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Year or Dates: 1966-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🎇 No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced 27 is marked other than "natural", traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian Andrew Miller, Sr. Betty Jane Linebaugh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 N. Cleveland Avenue, Hagerstown, Md. 21740 permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong 000ce. Karen Louise Miller - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 11-13-09 4 Donation 5 Other (Specify) Hagerstown, Maryland Rose Hill Cemetery 21. Signature of uneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung montz (and /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery death 3 | Ectonic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown the requires that signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ icate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No aw 24a, Was an 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-11-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Engres Herer hum M.O. SH 10+1 Medical 11/10 Corneck 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 12

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

	•	For State Registrar		State of	Mary			ment of H icate of I			fental Hyg	gien Reg. N	-	09	37	698
Physicia	n	1. Decedent's Name (First, Middle Dorothy E		beth	Mc(	Comb					2. Date of Dea Month November	D	2 (	009	3. Time of 10:00	
/Medica	200	4a. Facility Name (If not instituti Wilson Healt	on, give	street and nun	nber)		41	Gaither					c. County		·v	
Funeral Director		5. Social Security Number 015-26-3674	6. Se			78 Yrs	M	Under 1 Year onths Days		ler 24 Hrs.	8. Date of Birth (Month, Day Sept. 2			9. Birth	place (State o	
	tor	Usual Residence of Decedent  10a. State 10b. Count  Md • Mon	tgon	nery	10	c. City, Town o									10d. Inside C 1 ∐Yes	ity Limits
with the a or 28a- be notif	Direc	10e. Street and Number 28801 Greenbe	rrsi	Drivo				10f. Zip Code	)882			-	Citizen of V			
Ins a	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	arried	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	rces? 2 <b>⊠</b> No	r in U.S.					ecify Yes or No- Rican, etc.)		14. Rac	e - Americk, White,	can Indian,	
within 72 hor ene. than "naturi he Medical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	est grad	cation de completed) College (1	-4or 5+)	(C)	Give kin fe. DO	t's Usual Occup d of work done NOT use retired biologi	during n d)	nost of work	ing	16b.	Kind of Bi	usiness/Ir		
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nd 2 shoul lith and M. 27 is marl	Ĕ	19a. Informant's Name/Relation Donald R. McC			her	19b. N 288	Mailing A	ddress (Street Greenbe	and Nur	mberor Rui Driv	ral Route Numbe e, Layto	er, City	v or Town, Ville	State, Zi	p Code) 1. 2088	32
Pages 1 a ment of Heg ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 4 ☐ Donation 5 ☐ Other			State		cremat olit	ory or other place an Cren	n.	11/	Date 6/09	A1	exan		own, State Virgi	inia
permit. Departi Importa any Inj once.		21. Signature of Funeral Service	e Licen		004	70	22. N Mt P	ame and Addre	ss of Fa Ba ox 5	rber 038,	Funeral Laytonsv	Ho vil	me 1e, N	Md. 2	.0882	
Physician /Medical Examiner	ler	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	or complist only o	a. A  Due to	lzhei 1zhei (or as a co	imer Der	ment		ng, such	as cardiac	or respiratory ar	rest,			Approxima Interval Be Onset and 9 Yea	tween Death
physicia the bui	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	l	cDue to (	(or as a co	onsequence of)	:						1			
ding Physician: The law requires that the death certifiance this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown			oirth 2 D	oregnancy Fetal death ne of death		etopic pregnanc ther <i>(specify)</i>	у					ate of deliv	very Day	Year
w requires that been signed be should be determined.	þ	Part II. Other significant cond Decubitus U1		ontributing to de	eath but n	ot resulting in the	he unde	rlying cause giv	ven in Pa	art I.	23e. Did to		o use con 2🔀 No	tribute to 3 ☐ Pro	the cause of bably 4	death? Unknown
The law req	Completed								-		24a. Was autor perfo 1□ Yes		?	Were aut prior to co death? 1 ☐ Yes	copsy findings ompletion of	available cause of
siclan:   certifical	Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 ☑ No	cal	Hospital:	Innationt	2 ☐ ER/Outp	ationt	3□ DOA Oth	or.		th <i>(Check only o</i>		6 DO#	hor /Cnoo	i6.4	
This for the Hospital or Attending Physician: within 24 hours after dealth or the Funeral Director: After this certifical completely filled in by the funeral director,	ition: To	27. Manner of Death 1 Natural 5 Pen	ding stigation	28a. Date (Mon		28b. Tir	ne of	28c. Inju Wo			28d. Describe I				ay)	
To the Hospital or Attending R within 24 hours after death: To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Cou 4 Homicide dete	ld not be rmined	200. Flace	of injury ing, etc. (	- At home, farm Specify)	n, street	, factory, office			28f. Location (3 City or Tou	Street wn, St	and Num ate)	ber or Ru	ral Route Nu	mber,
the Hospit in 24 hour the Funera	Medical (	(Check only 2 Medic	al Exan	niner: On the b		amination and/		stigation, in my	opinion,	death occu	, and due to the tred at the time,	date	and place	, and due	to the cause	(s)
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8		30. Name and address of pers  31. Date filed (Month, Day, Ye.	M	drich		h (Item 23a) (T 911 Signature	Nu	stell 1	The		i then	rba	y /	no	. 208	79
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Physicia		tegistrar 1. Decedent's Name (First, Middl							2 Date of De	ath		3. Time	of Death	
Medical Examir			FRED		R JR.	4h Cihi To	en orlo	cation of Dea		Day er 15, 2009	nty of Death		0 hrs	
		4a. Facility Name (if not institution Civista Medical Cente		number)	[	LaPlata		Callon of Dec		Char	•			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 24h	_	Birth (MM/DD/Y	YYY) 9. Bir Foreig	thplace (	State or	
Director		213-27-5799	1XXM 2 F	2	5 Yrs	Months .	Days	Hours M	Nov.	2,198	0.	untry)	DC	
à		Usual Residence of Decedent		Inc. City	y, Town or Locat	ion						10d. Ins	side City L	imits
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ryland tryland tryland	Director	10e. Street and Number	res	п	ughesv:	111e 10f. Zip C	ode			10g. Citizen	of What Cou	ntry?		
ith the Maryland 23a or 28a-f show	Dire	12883 Corin	thian C	ourt		2	063	7		U.	S. A	٠.		
	era	11. Marital Status		ecedent Ever in U					Specify Yes or Norto Rican, etc.)		Race - Amer White, etc.	ican India	an, Black,	
r death wi	Funeral	1 XXNever Married 2 M	arried 1 Yes	$_2XX_{No}$		Yes 2				Spe	cify: Whi	te		
urs afte	٥	Widowed 4 Div	or Dates:		16a. Deceder	nt's Usual O	ccupatio	n (Give kind	of work done		of Business/			
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212 ould be I Ment in mark	10 B	19a. Informant's Name/Relations	ship (Type, Print)					and Number	or Rural Route N	umber, City o	r Town, Stat			
		Rickey F. N	iner Sr		er 5095				ce Whi	te Pl	ains,	MD S	2069	5
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the M diral Examiner		20a. Method of Disposition  1 XXBurial 2 Crematio	n 3 Remova	from State	crematory or o	ther place)		No	vember					
Baltimore, pernit. Pages I an Department of He Important: If ite	ш	4 Donation 5 Other S 21 Signature of Funeral Service			rinity	Mem.	Grd	ns. 1	9,2009 AYMOND	Wal	dorf,	Ma	ryla	ind
Balt permit. Departi	-	Loven Bas	tasse	) MO					N AVE.					
Physician		23a. Part I. Enter the disease, o failure. List only one cause	r complications tha	t caused the dea	th. Do not enter	the mode of	dying, s	uch as cardia	ac or respiratory	arrest, shock,	or heart	Appr	oximate In veen Onse	nterval
/Medical aminer	1	Immediate Cause (Final disease	a. Narco	tic (her		<u>toxic</u>	atio	n				4	Death	
		or condition resulting in death)	Due to (or a	s a consequence	of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		s a consequence	of):									
H	Examine	(Disease or injury that initiated events resulting in death) Last	C	s a consequence	e of):									
recuted ransit			d									-		
be es	edical	X UNPENDED		<sup>D</sup> 23a,27		erME,	G89	8 12/4	4/09 TT	1004 5	ate of delive	<u> </u>		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	W/u	IF FEMALE: 23b. Was decedent pregnant in		es, outcome of pro e birth		etal death	3	Ectopic pre	egnancy		onth	Day	Yea	ar
Box 6 e death cer the attendi	Physician/M	past 12 months?	den aus	egnant at time of	death 5 C	other (Spec	ify)							
O. Bc nat the der id by the a	Phy	Part II. Other significant cond	9 01	known g to death but no	t resulting in the	underlying	cause gi	ven in Part I.	23e. Di	d tobacco use	e contribute t	to the cau	se of dea	ith?
res that signed I be deta	d by								_ 1□	Yes 2 N				
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tal Recian: The certificate	Be C	25. Was case referred to medic examiner?					10	Dale on the	eck only one)					
of Vital Records, P. ng Physician: The law requires th After this certificate has been signe present director, page 2 should be d.	<b>To E</b>	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	✓ ER/Outpatie			Other Nork?	ursing Home 5	Residenc		ner:		
n of ding Ph	ion:	27. Manner of Death  1 Natural 5 Pe	(M	11/15/09				es 2 X No	1					
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Div pital or ours aft	Certification:	4 Homicide	ermined (Spec		d at hor				12883	Corith	nian C	t. H		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the aminer:On the ba	best of my know	ledge, death occ	urred at the	time, da	te and place, death occur	and due to the dred at the time, d	cause(s) and r late and place	manner as st e, and due to	tated. the caus	e(s)	
To th withii To th	Medical	29b. Signature and title of certi	and mann	er stated.				e number			te signed (M			
		3	0 111	16			O.C.N	И.E.		Nove	mber 15,	2009		
		30. Name and address of person		cause of death (I										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 28d per ME 9897 11/24/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 16:26 MARY A Naide P005-05-01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Stock Towner Center, University of Muyland Made | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr. 2, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 🛛 F 219-26-2439 70 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State 28a-f show ?? Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Madical Examinar must be notified at 1 □Yes XIXNo Seaford, DE Dorchester Director MI) 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6404 Cardinal Avenue 19973 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ∐Yes 2√1√No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 Is marked other I any injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Upman, Sr. Anna Mae Sellers ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alvin L. Naide/Spouse 6404 Cardinal Ave., Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Sh. Veterans 10/30/09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Framptom Funeral Home, l 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Ryspelle CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** raumatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHOUND leve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or se a concequence or, signed by the attending physician and be detached for use as the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, CERTIFICATION APPROVED BY MEDICAL EXAMINES Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 □ Yes 2 ☑ No Ö 9 ☐ Unknown <u>~</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ (gravary 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an .Νσηις has autopsy performed this certificate 1 ☐Yes 2 🗹 No 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 5 Pending investigation s after dea... ral Director: Aff 1 Natural 10-07-2009 UnknownM 1 ☐ Yes 2 ☑ No VALOUR Fall 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Willington, DE Seaford, DE Home 6404 Cardinals Rd. within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (0-26-2009 ory 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STC 22 S. Greene

MD

32. Registrar's Signature

**ORIGINAL** 

1 mount

OCT 28 2009

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 0'Nei11 November Alice Elsie 2:10 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5963 Solomons Island Road Tracy's Landing Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours Min. May 15% Year 924 Maryland 215-34-7191 85 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Tracy's Landing 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5963 Solomons Island Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed white oe filed with...
Mental Hygiene.
ad other than "natu...
\*t. the Medical Ey 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiens fitem 27 is marked other th waitress restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mervin Norfolk Bertha Norfolk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 5963 Solomons Island Rd., Tracy's Landing, MD 20779 C. Lorraine Dobson, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 👽 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 Donation 5 Other (Specify) Resurrection Cemeter 11/12/2009 Clinton. MD Signature of Funeral Service Le 22. Name and Address of Facility Rausch Funeral Home, P.A. any Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 4 9 Unknown signed by the a 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed? Yes 2 No 2 🗆 No 1 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer or Attending Natural work?
1 Yes 2 No 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, after determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Destriying Prijstication. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l 29b. Signature and title of certifier 3306 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

68760

Box

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2:37 PM Constance Joan Ottinger-Rook Jovember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖔 Months Days Hours Dec. 30,1932 Maryland 214-32-4434 76 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1050 Security Road 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George William Rook Madelyn Cromer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Hemphill - Son 1050 Security Rd. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 11-17-2009 20a, Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 X Cremation 3 Removal from State Smithsburg, Maryland 5 Other (Spe Ignature of Fur ral Service L 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myxedems Due to (or s a consequence of) PARIC 150 Due as a consequence of) Due to (or as a consequence of):

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Department of H
Important: If ite
any injury or ot Physician/ Medical Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria

signed by the a

page 2 should

Physician/

Medical

Director

Funeral

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Completed

Be

**Examiner** 

**Funeral** 

Director

ms 23a or 28a-f s must be notified

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Health and Mental Hygiene. tem 27 is marked other tha

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months
1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by efferion, Cardiopulnons 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Henedo'a autopsy performed' rs after deau... ral Director: After this ceru... Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 2 1 No 1 ← Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending work 2 Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUDITH MBAOUA, FLA

NOV 1

31. Date filed (Month, Day, Year)

5H-0

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 7/2009

State

within 24 hours after de To the Funeral Directo completed filled in by the

**ORIGINAL** 

32. Registrar's Signature

D62588

251 6. Anheron St. Hagestown MD

Month

death?

1 Yes

Year

24b. Were autopsy findings available prior to completion of cause of

2 🗌 No

November. 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Piper Wayne Kevin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** C U MBFRL If Under 1 Year | If Under 24 WMHS-MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Yea Jun 13, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 3<sup>Year)</sup> 1964 **Funeral** Days Min 1 □**x**M 2 □ F MD 212-84-9685 45 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Allegany Oldtown 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 17301 Wagner Road, SE 21555 USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced white "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event than "na once." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charley Piper Rozella Petenbrink Piper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11509 Valley Road NE Cumberland MD 19a. Informant's Name/Relationship (Type. Print) MD 21502 Evelyn Loar sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11-21-2009 Oldtown Cemetery MD Oldtown 4 ☐ Donation \$ ☐ Other (Specify) 22. Name and Address of Facility Part Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Paur / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, h. ck, or heart failure. List only one cause an each line. immediate Cause (Final disease or condition resulting in death) **Physician** neumonie 00 /Medical Due to (fir as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending ours after death.

Neral Director: Al
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled ACCEPTITY Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number ပ္

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

00033280

Nov. 18, 2001

25 KENT AVENUE CLUMBERLAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last, **Physician** [2:30 PM rances d6 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Cente Anapolis 8. Date of Birth (Month, Day, Year) Nov. 8.1932 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕱 F 76 Yrs Nov. Pennsylvania 235-52-2150 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the world Experience near be notified at 1X Yes 2 □ No Director Prince George's Bowie Maryland| 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12312 Starlight Lane 20715 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after □Yes 2 X No Yes, Give 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: ş 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Medical Technologist Medical 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela Veronica Padovini Samuel Robert Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12312 Starlight Lane Bowie, MD 20715 William Park/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/30/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** stem disease or condition resulting in death) /Medical Due to (or as a con **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine -transit The law requires that the death certificate be executed neumanic and Due to (or as a consequence of) attending physician a P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the ar 5 Other (specify) □Yes 2 No 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Dement 1 ☐ Yes 2 ☐ Yo 3 ☐ Probably 4 ☐ Unknown should k 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated To the I within 2 To the I

State Registrar

29b. Signature and title of certifier

acianna

31. Date filed (Month, Day, Year) OCT 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

raynham

mb

32. Registrar's Signature

29c. License number

D66 800

29d. Date signed (Month, Day, Year)

2001 medical Parkway, Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 28 2009 12:41 P M Egil Joseph Pawloski 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/13/1962 6. Sex 1∆ M 2□ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Norway 216-98-1605 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Riva 1 ☐ Yes 2 ☐ No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3027 Pike Drive 21140 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2X No If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Representative Copiers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Michael Pawloski Bjorg Lillian Ravnunger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3027 Pike Drive, Riva, Maryland 21140 Joan Y. Pawloski/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens: 11/05/2009 Davidsonville, Maryland 21. Signatury of Fun 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra abdopina disease or condition resulting in death) WELKS Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? for how 1(Espiratory 1 Yes 2 No 3 Probably 4 Unknown Bena 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 0 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No

**Physician** /Medical Examiner

The law requires that the death certificate be executed

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his certificate has b I director, page 2 sh

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To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

death.

After thi funeral

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If It Medical Examinations within a modified.

Baltimore, Maryland 21215-0036

/Medical

ner Examir signed by the attending physician and be detached for use as the burlal-transit Physiclan/Medical δ

Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident 6 ☐ Could not be 3 Suicide determined 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifies

29a. Certifier

29c. License number D 46052 29d. Date signed (Month, Day, Year) 28/09

State

Registrar

Sirual Bed, MD 31. Date filed (Month, Day, Year

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

Situal Bill, TVD 2001 Mithial Parkway anna pito

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per phys. G898 12/22/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Shirley Parker October Delores 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Medica Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 8 / 10 / 1940 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 69 1 □ M 2√2 F Yrs. 216-40-6977 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Maryland Charles Charlotte Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20622 USA 8710 Sum Pl. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Program Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph W. Cornish Sarah R. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8710 Sum Place, Charlotte Hall, MD 20622 William L. Parker/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 11/3/2009 Helen Maryland Queen of Pease 22. Name and Address of Facility 21. Signature of Funeral Service Licen Adams Funeral Home PA, Aquasco MD M1589 20608 23a. F. rt.1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lue to (or as a consequence of) onio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 1 No onths? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No 25. Was case referr to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1☐ Yes 2☐No 1 hpatient 2 ER/Outpatient 3 DOA 27. Ma or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Saltimore, Maryland 21215-0036 Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Pages 1 and 2 should be **Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, attending physician for use as the buria sate has been signed by the page 2 should be detached certificate 24 hours after death. e Funeral Director: After within 2 To the I the

Physician

Examiner

**Funeral** 

Director

28a-f show

or Items 23a or

"natural"

nd Mental Hygiene. marked other than "

Director

Funeral

Completed

Be

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Examiner

Physician/Medical

\$

Completed

Be

Medical Certification: To

29b. Signatur

30. Name

and title of certifies

CHOL

NOV

and address of person who completed cause of death (Item 23a) (Type, Print) M.D

32. Registrar's Signature

M UN

burial-tran

Injury or other traumatic event, the Medical Examiner sust be notified at

death with the Marylan

MR-09680°

/Medical

DHMH 17 Rev 1/2001

State

completely filled in by the funeral director,

31. Date filed (Month, Day, Year)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

00

6

Certificate of Death

2009

Frederick

14. Race - American Indian, Black, White, etc.

Specify: White

23d. Date of delivery

Day

Were autopsy findings available prior to completion of cause of

1 ☐Yes 2 🖾 No

Year

Month

Martinsburg, West Virginia 25405

4:45

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 □Yes 2 K No

Approximate Interval Between Onset and Death

months

Minnesota

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 6 2009

Alan Fischler, DO

31. Date filed (Month, Day, Year)

10+1

DHMH 17 Rev 1/2001

Registrar

510 Butler Avenue

32. Registral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line 5.25, per ME 8898 12/17/09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day\_ Physician/ Month Year Niki M. Queen-Rhoderick Medical byenh 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ashinator Washington County Hospital
5. Social Security Number 6. Sex 7. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 1 M 2 F Months Days Hours Min. (Month, Day, Year **Director** 215-62-6275 Washington D Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Washington <u>Keedysville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19058 <u>Keedysville Road</u> United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Completed by Black, White, etc. 1 Never Married 2 😾 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>Dominick M. Giampietro</u> Flavia Lombardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip F. Rhoderick/ Husband 19058 Keedysville Road, Keedysville, Maryland21756 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Poplar Springs Cemetery11/7/2009 21. Signat uneral Septice 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 621 Opossumtown Pike. Frederick. 23a. Part 1. Enter the disease, or complicat of s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition OKIC hoc Medical resulting in death) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine onsequence of): Due to for each The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Lntl g physician and as the burial-trans Due to (or as a consequence of) resulting in death) Last CERTIFICA Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifie 29c. License number BOName and address of person who completed cause of death (Item 23a) (Type, Print) 22911 Jetterson Bor ha 31. Date filed (Month, Day, Year, 32. Registra State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State Registrar	State of M	laryland /	Depa / Depa	artment of F tificate of	lealth and Death	Mental Hyg	giene	009	377	709
	<b>6</b> 1		1. Decedent's Name (First, Middle, Last	)					2. Date of Dea Month	Day	Year	3. Time of	
	Physicia /Medic		Ruby Fay	Robins	on				Nov.	16,	2009	1:00	РМ
	Examin		4a. Facility Name (If not institution, give		7)		4b. City, Town, o		ath	4c. Co	ounty of Deat Harf		
			2225 Engle Roa			hish to N	F'all	1ston	rs. 8. Date of Birt				or Foreign
п	Funeral		5. Social Security Number 6. Sec	х ]м 2∛С]F	ge (In yrs. last 91	Yrs.	Months Days	Hours Mi		Year) 191	8	hplace (State ountry)	C
	Director		219-12-9268 Usual Residence of Decedent		91				pune 10	1, 101			
	yiend wor		10a. State 10b. County		10c. City, Te	own or La	cation					10d. Inside C	
	Man	호	MD Harfor	d			Falls	ton				1 🗌 Yes	2 <b>X</b> No
	th the	Je l	10e. Street and Number				10f. Zip Code			•	n of What Co	-	
	15 wil	Funeral Director	2225 Engle Roa	d			210				J.S.A		
	r dee	In In	11. Marital Status	<ol> <li>Was Decedent Armed Forces</li> </ol>	?	13.	Was Decedent of his Yes, specify Cub	lispanic Origin? an, Mexica <i>n</i> , Pu	(Specify Yes or No arto Rican, etc.)	14.	Race - Ame Black, Whit	erican I <i>n</i> dian, e, etc.	
36	filed within 72 hours effer deeth with the Maryland Hygione. ther then "neturel", or Itama 23a or 28a-f ehow ent, it e Madical Examiner must be notified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates			1 ☐ Yes 🏂 No	Specify:		Sp	pecify:	White	
8	hour ture!	8 9	15. Decedent's Edu			6a. Dece	ient's Usual Occup	pation		16b. Kind	of Business	/Industry	
5	in 72 in 6	Set	(Specify only highest grad	le completed)		(Give	kind of work done OO NOT use retire	during most of v	rorking				
212	y with	Completed	Elementary/Secondary (0-12) 12	College (1-4o	3+)	Ass	sembly			Manu	facti	ıring	
þ	othe Vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle,	Maiden Su	imame)		
Maryland 21215-0036	s 1 end 2 should be flied within if Heelth end Mentei Hyglene. Item 27 is markad other then other traumatic event, Ite Ma	2	William Frankl:	in Blev	ins _			Mart!	na Franc	es G	ambi	11	
lan	end l		19a. Informant's Name/Relationship (T)						Rural Route Numbe				21122
	end eeith m 27 nar tr		Judy A. Baker/I	Daughte				ul's C	nurch Ro		esvlll tion - City or		21132
ore	or off		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from Stat	Jan	e or Dispo	sition (Name of natooy of other pla LSVIIIE	ce) No	v. 19,		·		
Ë	tant:		* 4 □Donation 5 □Other (Specify)			Ceme	etery		2009 .J. Harte			ville,	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylen Department of Heelin and Mental Hygiens. Important: If tem 27 is marked other then "naturel; or Itama 23a or 28a-f show any injury or other traumatic event, its Madical Examinar must be notified at once.		21. Signature of Euneral Service Licens	90		1	Name and Addre	oss of Facility J	, Stewa	rtste	own.	PA 17:	363
	TO = CO		23a. Part1. Enter the disease, or comp	lications that caus	ed the death. [							Approxima	te
			shock, or heart failure. List only o	ne cause on each	line.	A:	J. (115 1115 51 5)	g,	, , , , , , , , , , , , , , , , , , , ,	,		Interval Be Onset and	
	Physician /Medical		disease or condition resulting in death)	a	CVF	+							
1	Examiner			Due to (or a	is a consequen		1510N						
		5	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consequen		21010						
×	bens t	Examin	cause. Enter Underlying Cause (Disease or Injury that initiated events										
ó	exec en en riel-tr	EX	resulting in death) Last	Due to (or a	s a consequen	ice of):							
8760,	icete be executed physicien end s the buriel-trensit	dicai		d									
9	ing ph	Med	IF FEMALE:		-					1777			
Вох	eath certific ettending p for use as	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	ath 3	Ectopic pregnanc	у		230	<ul> <li>d. Date of de Month</li> </ul>	•	Year
-	the e	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown	at time of death	n 5L	Other (specify) _						
P.0	thet the de ned by the e detached t		Part II. Other significant conditions co	ntributing to death	but not resulting	ng in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco use	contribute to	o the cause of	death?
Records,	9 50	d by	•			·	, , ,		1 🗆 '	Yes 20	No 3□P	robably 4 🗆	]Unknown
Ö	w requir been si should	Completed							24a. Was	an i	24b. Were a	utopsy findings	available
Rec	The levelete hes	ם							- autoj	osy ormed?	prior to death?	completion of	cause of
_			25. Was case referred to medical					26 Place of [	1 ☐ Yes Death (Check only.c		1 🗌 Yes	s 2 No	
Vital	Physicien: this certific rel director,	To Be	avaminar?	Hospital: 1 ☐ Inpa	tient 2∏ER	/Outpatier	nt 3 DOA Ot	han	Home 5 Resi	196-	Other (Spe	ecity)	
			27. Manner of Death	28a. Date of In (Month, L		Bb. Time o	The second second		28d. Describe				
<u>ö</u>	nding l eth. r: After e funer	atio	1 DMatural 5 ☐ Pending 2 ☐ Accident investigation	(Morali, L	yay rear,	mjury		Yes 2 No					
Division	r Atte er der racto by th	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of I	njury - At home etc. (Specify)	e, farm, st	eet, lactory, office		28f. Location ( City or To		Number or R	lural Route Nur	mber,
□	ital or rei Di	Cer											
	To the Hospital or Attending within 24 hours efter deeth.  To the Funerel Diractor: After completely filled in by the fune	Medical Certification;	29a. Certifier ↑ Certifying Phy (Check only 2 Medical Exam	iner: On the basis	of examination	idge, deat n and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the ocurred at the time,	cause(s) ar date and pl	nd manner a lace, and du	s stated. e to the cause(	(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licen	se number		29d. Date :	signed (Mon	th, Day, Year)	
	2 × 5 0		A Section of Continor	Λ	1		1			111	1,010	9	
			30. Name and Idness of person who c	ampleted assess	death (line or	39) / Т	Print)	1127	57E 401	111	1 110	/	
	0		1	SASS 7		A/	CHADIA	es ar	574 co.11	> 4	25	11/2/2	4
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	0	es	_رر	310 400		701	-0 0100	T
	Regist		NOV Z & ZUUS	Canona	P. 19	1100							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 16, 2009 **Physician** 10:45pm <sup>M</sup> Russell Rinehart Jr James /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Golden Living Center Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jul 3, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 215-34-3911 1 X M 2 □ F Maryland 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County r than "natural", or items 23a or 28a-f show the Medical Exa., incr. must be notified at 1 X Yes 2 □ No Frederick Frederick Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21701 419 Columbus Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give V1.0+p.e 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify If Yes, Give Year or Dates: Vietnam Specify: White 2 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Shipping/Receiving College (1-4or 5+) Elementary/Secondary (0-12) NIST- Fed Government 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Evelyn Bover Sr Russell Rinehart, James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 21702 7323 Granalta Circle, Frederick, R. Wayne Rinehart, Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Nov 20, 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Kic Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature 106 East Church St, Frederick, Maryland 21701 ) M00706 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or all a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be deta Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 No certificate 1 TYes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 26. Place of Death (Check only on in by the funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 00 47951 11-17-2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Toll House Ave FREDERICK. 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John Francis Ropek 4:50 A M November 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-03-1917 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. PĂ 92 Director 108-10-1115 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must han marked and Injury or other traumatic event, the Medical Examinar must han marked and injury or other traumatic event, the Medical Examinar must han marked and injury or other traumatic event, the Medical Examinar must han marked and injury or other traumatic event, the Medical Examinar must han marked and injury or other traumatic event, the Medical Examinar must han marked and injury or other traumatic event, the Medical Examinar must have a second and injury or other traumatic event, the medical examination of the properties 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Calvert Lusby 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13020 Surf Street 20657 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced WW II Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U S Government Weather Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franciszek Ropek Josephine Kyowski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Larson (Niece) 14960 Carry Back Drive, Darnestown, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 11/10/09 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600. Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 3days /Medical Due to (or as a consequence of): **Examiner** I week CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CKD, HTM, COPD, PAD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe 1 ☐ Yes 2 ☐ ★6 To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 errifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/09 D36969 dru 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 SCARIA MATHEW MD, 20657 MD LUSBY PU BOX 1789 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 8 per fh,g906,08/04/2010dhb Certificate of Death Reg. No. = State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Day 9, 2009 5:15pm м Madeline Ross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Clinton Southern Maryland Hospital 5. Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 M d **Funeral** 1 □ M 2 🔏 F Months Days Hours Min. 90 10/29/1919 Md. **Director** 214-36-3147 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No Charles Nanjemoy Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2805 Port Tobbaco Road 20662 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: 3X Widowed 4 ☐ Divorced Black permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Housewife</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jamie Henson James Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Port Tabacco Rd., Nanjemoy, Md. 20662 Delphie Ross/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/5/09 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Church Nanjemoy, Md. Signature of Fungral Service Licensee 22. Name and Address of Facility Bluford Funral Service MOJZO 2019 Martin Luther King Ave. Wash., DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ a ACUTE MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURF KENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one)

Box 68760 P.O. Records, certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; t Division of Vital

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

29b. Signature and title of certifier

ATTENDING PHYSICIAN

D52900

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 10-31-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD, GLENN DALE. MD 20769 MUSA MOMOHMD 12150 ANNAPOUS

31. Date filed (Month, Day, Year) State Registrar

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Certificate:

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arthur A. Rudmann October 2009 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center **Annapolis** Anne Arundel 6. Sex. 1 A M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 0870471934 New York 115-24-8387 75 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show marke other than "natural", or items 24a or 28a-f show marked other than "and it was the motified at matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 740 Ballast Wav 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Yes 2 No Black, White, etc. 1 Never Married 2 M Married ģ 1 ☐ Yes 2 No Specify 3 - Widowed 4 - Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, the once. Aeronautical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank J. Rudmann Margaret Bartell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Rudmann/Wife 740 Ballast Way, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Kalas Crematory 10/29/2009 Edgewater, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Rart X. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Caulio ing o paths disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASCAP Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year 1 Yes 2 No 9 Unknown 9 Unknown ģ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Robt M. Gre 026373 10-28-2009 Robert Greenfield 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 151 Aungolis 139 dl Solomons 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 1:50P lberta Kankins Ann 2009 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice 5. Social Security Number 6. Sex Wicomico ale 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Hours 65 Yrs. Months 213-42-0700 Director June 30 1944 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f st
other traumatic event, the Medical Exertions or continued MD Wicomico 1 ☐ Yes 2 No **Funeral Director** Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21804 109 Avenue Benjamin United States 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Campbell's Soup Co, Elementary/Secondary (0-12) College (1-4or 5+) Processor Data G. E. D 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnson Mary Elizabeth John ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Benjamin Avenue, Salisbury, MD 21804 JR./Spause Herndon Rankins, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/09 East New Market, MD Thompsontown Cem. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral 216 N. Main Street, Federals burg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON **Physician** CANCEN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed signed by the attending physician and ibe detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 122 nonths?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 🗌 Yes this certificate has been siral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 3 1 ☐ Yes ∕2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence To Other (Specify) HOSPICA 1 Yes 2 1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 1005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1300 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Daniel Webster Swann 03 200 NOVEMber 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth Pars Hours Min. 9 (100th, Pars) 2017 UI'STA MEDICAL CENTER Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Maryland 216 22 2442 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 1 Yes 2 No Waldorf Charles MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 USA 721 Hatfield Ct Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc Never Married 2 Married 1 □Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Private 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Frances Swann Julian E. Swann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
721 Hatfield Ct. Waldorf Md 20602 19a, Informant's Name/Relationship (Type. Print) Dora F. Goldring 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial 20c Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11-6-2009 Waldorf 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses 2294 Old Washington Rd. Waldorf Md 20601 Kimberly onic Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a con SA neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for he a considerate off Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar P.O. Box 68760, attending physician for use as the burial ed by the cate has been signed by page 2 should be detacl Division of Vital Records, certificate funeral director, this

After 1

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

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**Funeral** 

Director

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death with

I and 2 should be filed within 72 hours after

Pages 1

and Mental Hygiene.

Is marked other than

Health sm 27 l

Injury or other

Department of Heal Important: If item 2 any Injury or other

Physician /Medical

Examiner

Maryland 21215-0036

Baltimore,

5

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at

Physician/Medical þ Completed Be Certification: To n 24 hours after death.

e Funeral Director: Aft

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 No

5 Pending investigation 6 Could not be determined

Date of Injury (Month, Day, Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 Terrace Drive Ste 103, Waldon

29b. Signature and title of certifie

29d. Date signe# (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mani Sha Tariwaa, MD 1163 ariw Manisha

MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 2009

State Registrar

completely

within 2

		1 - State Of Mary		ertificate of l		Reg. N	6007	3//16
Physicia	an	1. Decedent's Name (First, Middle, Last)  Bessie A. Smith					ay Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death		2, 2009 c. County of Deat	19:00 A
Examin	er	Solomons Nursing Home		Solomor			Calver	
Funeral		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign
Director		121-32-0057   1 M 2 X 93	Yrs.	. World Days	THOUSE THE	(Month, Day, Yea 9/12/191	6 Ne	w York
wo.		Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or	Location				10d. Inside City Limits
i si	tor	Maryland St. Mary's	(	Chaptico				1 □Yes 2√ No
or 28	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Co	untry?
23a		24850 Lucie Beall Ln.		20621			USA	
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ones.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U.S. 1	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>1 □ Yes 2 No</li> </ol>	Ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
natri	eted	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of worki	16b.	Kind of Business/	Industry
han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	l l				Hair Dre	sser
Hygie ther t		12th  17. Father's Name (First, Middle, Last)	36	elf employe		(First, Middle, Maide	en Surname)	
ked o	To Be	Charles Sickler				ry Robert		
and M mari	۲	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street a	and Number or Rura	I Route Number, City	or Town, State, 2	Zip Code)
alth a		Debbie Boyd/ Daughter	248	350 Lucie_E	Beall Ln.	Chaptico	, MD 206	21
of He fitem		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State		sposition (Name of rematory or other place			Location - City or	
ment tant: I jury o		4 Donation 5 Other (Specify)	Kalas (	Crematory	11/3	3/09 Ed	gewater,	MD
Dupar Import any in		21. Signatu 1 off-ineral Service Licensee		22. Name and Address 2973 Solon	<sup>ss of Facility</sup> Geo nons Islar	orge P. Ka nd Rd. Edg	las Fune ewater,	ral Home MD 21037
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ne attending ed for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at times a continuous pregnant at times pregnant at	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	у		23d. Date of de Month	ivery Day Year
ned b e deta	by Phys	Part II. Other significant conditions contributing to death but n	ot resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
en sig	ed b	_ Sicie since syne	rome	2		1 □ Yes	2 □ No 3 □ Pi	obably 4 Unknown
page 2 sho	Completed	Skin concer				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
sertific sctor,	Be (	25. Was case referred to medical examiner?		100	26. Place of Death		1	
this c	2		2 ER/Outpat		4 L3 Nursing Hol	me 5 Residence		cify)
After funer	ion	27. Manper of Death  1 ■ Natural 5 □ Pending  2 □ Accident investigation	ear) 28b. Time Injur	y Work	yat ⟨? Yes 2 □No	28d. Describe how in	jury occurred	
after death	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Place of Injury building, etc. (3	At home, farm, Specify)			28f. Location (Street City or Town, Sta		ural Route Number,
in 24 hours he Funera pletely fille	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of manual Examiner: On the basis of example and manual manual Example 200 and manual Exampl	amination and/or	eath occurred at the tir r investigation, in my o	me, date and place, pinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
To t	Ž	29b. Signature and title of certifier  Lyan, C. S	won	29c. Licenso	5065	3 11	Date signed (Mont	
3 Sta		30. Name and address of person who completed cause of death  5851 - Ducele CM  31. Date filed (Month, Day, Year)  32. Registrar's	unch	e, Print) GyA	waid.	Deal	WA e m'E	2015
Registra	ar	NOV 05 2009 Jeneur	U M.	gare				

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Challe Days			For Amend		e Type o			P2/ <b>987</b>	e danse e	f He	alth a					ible.	00	771
			Registrar					Cer	tificate c	f De	eath			Reg. No	0.20	07	31	//
-	Physicia Medic	al	1. Decedent's Name (Fill Tina Mar	rie Sn	ıi th								2. Date of De Novemb		ť 20	Ŏ <sup>g</sup> r	3. Time of De 22:05	eath M
-	Examin	er	4a. Facility Name (if not Washingto	on Cou		oita				ers	town			40	Was	of Death hing		
	Funeral Director		5. Social Security Numb	3	3. Sex 1 ☐ M 2 🗶 F	7. Ag	e (In yrs. la 53	st birthday) Yrs.	If Under 1 You Months Da		f Under 2 Hours	24 Hrs. Min.	8. Date of Bi	rth ay Year)	1956		place (State or F rtry) cyland	oreign
	nd now st	يا	Usual Residence of Dec 10a. State 10	b. County			10c City	, Town or Lo	cation							T	10d. Inside City	Limite
	MD Washington Hag								erstown							1 Yes 2		
	vith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 806 Lanva	r						10f. Zip Code 10g. Citizen of 21740						hat Cou	ntry?	
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married  3 Widowed 4	2 <b>K</b> Mami	12. Was De	orces? 2 🔀 ive	Ever in U.S No		Was Decedent of Yes, specify C	uban, f	Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	-	14. Race Black Specify:	- Americ k, White, W	en Indian, etc hite	
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212	within 7 giene. <b>ser than</b> t, the M	Son	Elementary/Seconda	ay (0-12)	College	1-4 or 5	i+)		o not use reti. omema ke						own l	home		
Baltimore, Maryland 21215-0036	ould be filed wit nd Mental Hygie marked other matic event, th	To Be	17. Father's Name (First) Melvin L.		*					18	8. Mother Bett	r's Name	(First, Middle,	, Maiden	Surname)			
lary	should nand Me		19a. Informant's Name/	/Relationshi	o (Type, Print)			19b. Mailir	ng Address (Str	eet and	l Number	r or Rura	Route Numbe	er, City o	r Town, St	ate, Zip (	Code)	
6,	1 and 2 of Health item 27 other tr		Mark T. Sn 20a. Method of Disposit		husban	<u></u>	Look Bu		anvale		eet,						<u> </u>	
timor	permit. Page 1: Department of I Important: If ite any injury or of		1 Burial 2 X C 4 Donation 5	Cremation		n State	ce	emetery, cren erstow	sition (Name or natory or other n Crema	olace) tor		1/13		Hag	gerst	own	own, State	
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-	Medical Examiner		resulting in death)	_ (	Due to	or as	a conseque		cenhalo	mat	hv							
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Division of Vital Records,	Physician: The law rec this certificate has bee al director, page 2 sho	Completed											24a. Was auto perfo	psy ormed?	pr de	rior to co eath?	psy findings ava mpletion of caus 2 X No	ilable se of
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j Vi	Physi rthis o	일	1 Yes 2X No	0	1 ) 28a. Dat			R/Outpatier 28b. Time of	t 3 L DOAL	Other:			ne 5 Resi 8d. Describe I			-	)	
uc	nding ath. r: Afte ne fune	icat	2 Accident	☐ Pending Investiga	ition	nth, Day	r, Year)	injury	v	ork?	s 2 🗆 I		ou. Describe i	now injui	y occurred	•		
Division	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director-After this completed filled in by the funeral di	Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	Could no determin	ed 28e. Plac		iry - At hor c. (Specify)		eet, factory, offi	ce		2	8f. Location ( City or Tou			or Rura	Route Number,	
_	n 24 hour n 24 hour ne Funera	Medical	(Check 2 🗌 I	Medical Ex	Physician: To the aminer: On the bal lurse Practioner	asis of e	xamination	and/or invest	igation, in my o	pinion, c	death occ	curred at	the time, date a	and place	e, and due	to the ca	use(s) and manne	er stated.
	To the vithin comp		29b. Signature and title	of certifier					29c. Lic		ımber	,,			te signed		Day, Year)	, c <sub>2</sub>
			30. Name and address of		no completed car	ise of d	eath (Item	23a) (Type, P	rint) Hagerst	ดพท	MD	2174	.0	De	L.	00.	200	1
	Stat	e	30. Name and address of Ghazala C	ay, Year	1190 11	Registra	ar's Signatu	ire Control		J 1711								
	Registra	ar	TIFC :	I A ZU	UD CEN		1	//										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Vovenb <u> Iack Allen SHILLINGBERG</u> Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, ) Year 1931 Days 1**X** M 2 □ F Hours Virginia Nov. Director 5-26-1228 Usual Residence of Decedent 10d. Inside City Limits 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturant, or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No Hagerstown Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21740 17318 Ontario Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates the Medical 16h Kind of Rusiness Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Sandblasting ed other than " College (1-4 or 5+) Elementary/Seconday (0-12) Equipment Mfg. Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eliza Ellen Booth ည Samuel Johnson Shillingberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17318 Ontario Drive, Hagerstown, Md. 21740 Dee Shillingberg - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Dremation 3 Removal from State injury or Hagerstown, Maryland Hagerstown Crematory 11/13/09 4 Donation 5 Other (Specify) Signal and of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 21740 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TAPTIYLOCOCK Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Tetal death Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HEART 3 Probably 4 Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an inis certificate has b il director, page 2 sh autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2. No Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide Investigation 6 Could not be 24 hours after deatle Funeral Director: completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and use to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who

completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

130

		For State Registrar	State of Ma	ryland /	•	artment of H		nd Me	_	giene Reg. No.(	211119	37719
Physicia /Medic		1. Decedent's Name (First, Middle, Li Timothy H.	Sylvester	-				2.	Date of Dea Month	ath Day	2009	3. Time of Death  13:31 P M
Examin		4a. Facility Name (If not institution, gi University of Mar	ive street and number) yland Mudi	al Cen	ten	4b. City, Town, or Bultiv	none				County of Death	
Funeral Director		221-44-6442	Šex 7. Age 1. M 2□ F	(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birl (Month, Da IOV • 4	y, Year)	Cou	place (State or Foreign ntry) aware
Maryland -f show find at	tor	Usual Residence of Decedent  10a. State  10b. County  Delaware Kent		10c. City, To		cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the M or 28a-f	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	ntry?
Man y failed Lizer 5000000 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It we had early investigated at	/ Funeral	2568 Spectrum Far  11. Marital Status  1  Never Married 2 Married	rm Rd.  12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give	ver in U.S.		19943 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	ispanic Orig in, Mexican, Specify:	in? (Specif Puerto Ric	fy Yes or No can, etc.)		4. Race - Ameri Black, White,	
hin 72 hours e. an "natural", Mudical Ext	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest g.  Elementary/Secondary (0-12)	Year or Dates:		a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation	of working			Whi	
led with tygiene tymer tha her tha		12  17. Father's Name (First, Middle, Las	6		ccou	ntant	19 Methor	da Nama /F	First, Middle,		counting	<u> </u>
an ylaitta ATA is should be filed within and Mental Hygiene. Is marked other than aumatic event, the Management is should be a	To Be	Nolan Sylvester						,	Youn		<i>Jumame</i> ,	
2 shound hand hand hand hand hand hand hand ha		19a. Informant's Name/Relationship				ng Address (Street						p Code)
permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		Christopher Sylve  20a. Method of Disposition   ☆ Burial 2 □ Cremation 3 I  4 □ Donation 5 □ Other (Spec	☐ Removal from State	20b. Place ceme	of Dispo tery, crer	sition (Name of natory or other place	e)	na, I	e	20c. Lo	cation - City or To	own, State Maryland
permit. P Departme Importan any Injur		21. Signature of Funeral Service Lice		Green		o Cemeter Name and Addres Fleegle 2 106 W. St	ss of Facility	lfent	ein F	uner	al Home	yland 21639
≻ Physician ⊁ /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused y one cause on each lin  a. Due to (or as a	the death. Die.	o not ent	ter the mode of dyir	ng, such as o	cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death c-ritificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for us, as the burial-transit.	dical Examiner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									
he death critific the attencing p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live birth 1  Pregnant at 9  Unknown	2 🗌 Fetal dea		☐ Ectopic pregnanc ☐ Other ( <i>specify</i> ) _	у			2	23d. Date of delive Month	very Day Year
equires that the sen signed by the detactional of the detactions.	Ď	Part II. Other significant conditions	contributing to death bu	it not resulting	in the u	nderlying cause giv	en in Part I.			obacco u		the cause of death?
The law recate has bee page 2 short	Completed							_	24a. Was auto perfo 1 🗆 Yes		24b. Were aut prior to co death? 1 ∐Yes	opsy findings available ompletion of cause of
VILC rsician s certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗆 ER/0	Outpatie	nt 3 DOA Oth	or:		Check only o		G ☐ Other (Spec	ifu)
inding Phy ath. rr: After thi	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b	o. Time o Injury	f 28c. Injur Work		28	d. Describe			
tal or Atternal Director	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of Inju	:. (Specify)					City or To	wn, State)		al Route Number,
the Hospi in 24 hou the Funer ipletely fil	Medical	(Check only 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	examination		nvestigation, in my o	pinion, deat			date and	place, and due	to the cause(s)
To with To con	2	Control of the	inell mo			*	2137				e signed (Month	
		30. Name and address of person who Courtney Far	o completed cause of de	eath (Item 23a 22 S.	a) (Type,	erne St.	Ba	Uhm	ione,	mi	0 212	101
Sta Registr		31. Date filed (Month, Pay, Year)	32 Registra	ar's Signature	po	Print) lene St						

DHMH 17 Rev 1/2001

			1 - State of Maryland / D	epartment of Health Certificate of Death	and Mental Hygie	ene g. No. 2009	37720
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Kim D. Stewart		2. Date of Death Month OCTOBER	Day Year R 28, 200	3. Time of Death
	Medi Examir		4a. Facility Name (if not institution, give street and number) Saint Joseph Medical Cente	4b. City, Town, or Location of		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 1 1 1 1 2 1 9 - 76 - 0 7 5 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Dave Hours	24 Hrs. 8. Date of Birth Min. Jan. 12ay, Ye	ear) 965 g. Birth	nplace (State or Foreign ntryMary1and
	show dat.	,	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of the county	or Location			
	Marylar 28a-f sh ootified	irecto	MD Baltimore	Towson			10d. Inside City Limits 1    Yes 2 □ No
	n with the is 23a or nust be r	Funeral Director	10e. Street and Number 111 West Road	10f. Zip Code 21204		g. Citizen of What Cou United St	•
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☒ No  If Yes, Give  Year or Dates.	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican     □ Yes 2  No Specify:	, Puerto Rican, etc.)	14. Race - Ameri Black, White, Specify: B	
Maryland 21215-0036	within 72 ho giene. ier than "na t, the Medic.	Completed	(Specify only highest grade completed) ((College (1-4 or 5 t)	lecedent's Usual Occupation  alive kind of work done during most fe. DO NOT use retired)  Disabled	t of working	6b. Kind of Business Ir	ndustry
yland	lid be filed Mental Hy <b>larked oth</b> atic event	To Be	17. Father's Name (First, Middle, Last) Norman Larry Thomas	18. Mothe Ter	er's Name <i>(First, Middle, Mai</i> esa Stewar	den Surname) t Butler	
	nd 2 shou ealth and m 27 is m		Sharonda Butler/Sister 18b. Name/Relationship (Type, Print) 18b. Name/Relationship (T	Mailing Address (Street and Numbe 795 Myra Dr.,	r or Rural Route Number, Ci Bridgevil	ty or Town State, Zip Ie, DE 19	Code) 9933
Baltimore,	t. Page 1 ar tment of He rtant: If iter ijury or oth		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Federa	isposition (Name of crematory or other place) 1 Hill Cemetery		oc. Location - City or T ederalsbur	own, State g, Maryland
Ba	permit Depar Impor any in		21. Signature of Tuneral Dervice La Insee	22. Name and Address of Facility Framptom Fur	1	216 MMeinst	Federalsbim, MD
	Physician/ Medical	85 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. CARDIOFULMOI resulting in death)	enter the mode of dying, such as o			Approximate Interval Between Onset and Death SOON
-	Examiner	_	Due to (or as a consequence of):	ζ			HOURS
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, If any, loading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. ASPIRATION    Due to (or as a consequence of):	PNEUMONIA			HOURS
09	e be ex ysician e burial	dical E	d.				
	rtificate ling phr e as th	/Med	IF FEMALE:				
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3  Ectopic pregnancy 5  Other (specify)		23d. Date of deliv Month	ery Day Year
ds, P.O.	v requires that to been signed be should be deta		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		cco use contribute to the	ne cause of death?
Records,	The law re cate has be page 2 sho	Completed by	FAILURE TO THRIVE		24a. Was an autopsy performer 1  Yes 2	prior to co	psy findings available mpletion of cause of
of Vital	Physician: The this certificate ral director, pag	m I	25. Was case referred to medical examiner?  1 X Yes 2 □ No  Hospital: 1 □ Inpatient 2 XER/Outpo	26. Place of Death	h (Check only one)		
of V	y Physer this eral di	e: 10	27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c, Injury at	rsing Home 5 Residence 28d. Describe how in		)
ion	ttending I death. :tor: After / the funer	Certificate:	1 X Natural 5 ☐ Pending (Month, Day, Year) inju 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	ry work? M 1 ☐ Yes 2 ☐ I		njury occurred	
Division	ital or Attend urs after death ral Director: / lled in by the f		4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Si		
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Med	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea control only one)  2 Medical Examiner: On the basis of examination and/or in the control only one)  3 Certifying Nurse Practioner: To the best of my knowledge.	vestigation, in my opinion, death occ	curred at the time, date and of	lace and due to the cal	use(s) and manner stated
	Mith		29b. Signature and title of certifier  All Ou walson	29c. License number D12849		Date signed (Month, I	
		- 1	30. Name and address of person who completed cause of death (Item 23a) (Typ  A. HOMTO GHILODI, Ma.D. 7671 09		THORN MADVE	OND DISC	/
	Stat Registra	e	31. Date filed (Month, Day, Year)	WEN DRIVE II	OWSON, MARYL	HNU MINK	**
DHI	MH 17 Rev 7/20	- 1	MOTO COMMENT				

Kn

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>, 2009 **Physician** Charles Denis Shipley, Sr. November 12:15 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Genesis College View Nursing & Rehab Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□ F Months Days 214-32-9565 74 Director Sept. 19, 1935 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County In than "natural", or items 23a or 28a-f show the Mcdical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 12⊠Yes 2∐No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1582 Andover Lane 21702 Funeral United States death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☑ Yes 2 ☐ No 1956-permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Modical Examine. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No \$ Specify: Specify: White 3 ☐ Widowed 4 🔀 Divorced 1958 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Folder Operator Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert W. Shipley Florence Anderson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammie Baugher / Daughter 1582 Andover Lane, Frederick, MD 21702 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  $4 \square$  Donation 5  $\square$  Other (Specify) 2009 Frederick, Maryland Memorial Gardens 21. Signatura of Foll eral Servic Licens Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, shock, or beart failure. L Immediate C. use (Final disease or condition resulting in death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between t only one cause on each line. Onset and Death **Physician** meilmonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of); physician and the burial-transit be executed Due to (or as a consequence of) Box 68760 Physician/Medical requires that the death certificate ast IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ W 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 2 No 1 □Yes 2 No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1-Natural 5 Pending investigation death. 1 ∐Yes 2 □ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen 0 31. Date filed (Month, D State ark. Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year Patsy F. Smith 2009 /Medical 31 11:23p October 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min Yrs. Director 219-34-0583 13, 1938 Maryland Jan. Usual Residence of Decedent the Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner naust be notified at Director 1 ☐ Yes 2 ☑ No Maryland Howard Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumaite event, II! & Modical Exergine, man Funeral 1045 Long Corner Road 21771 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Harry W. Frizzell Helen Harne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 Timber Ridge Drive, Mt. Airy, Maryland 21771 Don Frizzell/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department o Important: If I any Injury or once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/6/2009 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Gardens Sykesville, Maryland 21. Signature Funeral Service 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic Obstructive Pulmonary Disease years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immuful cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ZNo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been a page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 Z No 2 🗆 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Certification: 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of excifier 29d. Date signed (Month. Dav. Year) 29c. License number D26499 November 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4 Culwell Drive, Mt. Airy, Maryland 21771 Ronald E. Miller, M.D. 31. Date filed (Month, Day, Year) 32. Registra s Signature State 2009 ▶ NOV BARRAN. Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Ida R. Taylor 8:45 p /Medical November 5, 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Unde Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 💢 F **Director** 216-22-2392 <u>June 19, 1928</u> NJ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Saint Mary's Scotland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 49499 Fresh Pond Neck Road 20687 USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 X No \$ Specify. 3 Widowed 4 ☐ Divorced "natural" Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Laundry Attendant Navy Exchange 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental ဂ္ John Holley Lillian White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. Joanne Beamon - daughter
20a. Method of Disposition 45502 Westmeath Way c13, Great Mills, MD 20634
Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Luke UMC Cemetery November 11, 2009 Scotland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blades a. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manper of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Injury 1 Natural 2 Accident 5 Pending 2 □ No investigation 1 Yes 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

dew 3

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital Records.

Division

Fort Lookout Rd, Leunssactown,

Victor Simon Tay		St I- For State	ate of Maryla	nd / Depa		Health an		Hygiene	Reg. No. 201	09 3772
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Middl Victor	<sub>e,Last)</sub> Simon	Taylo	or			2. Date of Dea Month Novembe	ath	3. Time of Death 0209 hrs
		4a. Facility Name (if not institution Fort Washington Hosp	•	nber)	4	Fort Washi		eath	4c. County of Dea Prince Georg	
Funeral Director		5. Social Security Number 090 76 1167	6. Sex	7, Age (In yrs. Ia 24	ast birthday) Yrs	If Under 1 Year Months Day		Min	irth(MM/DD/YYYY) 9. B Fore 1 27, 1985	ign
d now any e.		Usual Residence of Decedent 10a. State 10b. County VA		10c. City,	Town or Locati	on andria				10d. Inside City Limits  1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 5302 Tessie Te	 rrace #218	 3	711070	10f. Zip Code 223	09		10g. Citizen of What Co	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 M	arried Armed Fo	2 XNo	lf Y	s Decedent of Hises, specify Cubar	n, Mexican, Pu	( Specify Yes or N erto Rican, etc.)	White, etc.	erican Indian, Black,
72 hours afte n "natural", al Examiner	۾	15. Decedent's Education (Spe Elementary/Secondary (0-12)	orced If Yes, Give Year or Dates: cify only highest grad College (1-	e completed)	16a. Deceden during m	t's Usual Occupa ost of working life	tion (Give kind		16b. Kind of Business	s/Industry
15-0036 filed within 7 1 Hygiene. ed other than t, the Medica	Be Completed	12 17. Father's Name (First, Middle, Patrick Lewis	Last)		Carp	enter		ame (First, Middle,	Priva Maiden Surname)	ate 
MD 2121 d 2 should be fi th and Mental n 27 is marked tumatic event,	ToB	19a. Informant's Name/Relations Iman Taylor-Le	hip (Type, Print) Wis/sister				et and Number		ımber, City or Town, Sta	
Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Sp			rematory or ot verdale	Park Cre	matory		20c. Location - City Riverdal	e, MD
Balt permit. Depart Import injury	9	21. Signature of Funeral Service	Busca	Towe					ONIC FUNER	
Physician /Medical xaminer		23á. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a Multiple Gu		ds	he mode of dying	, such as cardi	ac or respiratory ai	rrest, shock, or heart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couce (Disease or injury that initiated	C	consequence of						
		events resulting in death) Last	Due to (or as a dAMENDED	consequence of	f):					
S .p .E	sician/I	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	23c. If yes, o	ant at time of de	2 Fe	stal death 3 her (Specify)	Ectopic pre	egnancy	23d. Date of deliv Month	ery Day Year
ords, P.O. Bow requires that the dessible to see signed by the should be detached fahould be detached faho	ed by Phy	Part II. Other significant condit	ions contributing to	death but not re	esulting in the I	underlying cause	given in Part I.	1Y	tobacco use contribute es 2 No 3 P	robably 4 Unknown
Record The law req icate has bee	Completed							perf		
n of Vital ling Physician: After this certi funeral director	To Be	25. Was case referred to medica examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pen	Hospital: 1 II	npatient 2 🗸 of Injury Day Year)	ER/Outpatient 28b. Time of 0109 hrs	DOA 28c. Injury	Other No Nother Nother	28d. Describe	e how injury occurred	ner:
Divisior To the Hospital or Attend within 24 hours after death To the Finueral Director:	Certification:	3 Suicide 6 Couldete	a not be	e of Injury - At ho Parking Lo		et, factory, office	building, etc.	or Town.		Rural Route Number, City ead, MD
To the Hos within 24 h To the Fnu	edical	one) 2 Medical Exa	miner:On the basis of and manner st	of examination a	ge, death occu nd/or investiga	tion, in my opinio	n, death occur	and due to the car red at the time, dat	use(s) and manner as s	the cause(s)
	2	29b. Signature and title of certific		a of death (Itam	(20)	1	.M.E.		November 7, 2	
OCME	ate	<ol> <li>Name and ad for sof or Mary G. Ripple MD.</li> <li>Date filed (Month, Day, Year)</li> </ol>	Deputy Chief N	,	miner 11	1 Penn Stree	et, Baltimore	e, MD 21201		
Registr  DHMH 17 Rev 1/20	rar		1009 Pere	un B.	ORIGINA	,				
OCME 2006	-1				OKIGINA	·-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthony Month Day Tartaglia Year Roy 6:00 P M 2009 Medical JOVEMBEX 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Co. 5. Social Security Number If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday If Under 1 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye Months Days Hours 200-46-3405 Pennsylvania Director 55 <u>June</u> Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Pennsylvanjia Franklin Waynesboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 West Third Street 17268 United States permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Commercial Industrial Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Refractorial Material Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincenzo Tartaglia Noemi Della Lazino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 West Third St., Waynesboro, Pennsylvania 17268 Karen Tartaglia Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 【 Removal from State Harrisburg, Pennsylvani Pennsylvania Cremation November 10, 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Se Inc. Lochstampfor 48 S. Church Funeral Home, I St., Waynesboro 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a conse veno of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Day Month Year 2 No has been signed by the je 2 should be detached Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions gontributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Xes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate ha autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident 1 Tyes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05H-14 State

DHMH 17 Rev 7/2009

Registrar

MID

an 32. Registrar's Signature

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37726 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month THOMAS Year 1930AM 11 2009 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death General BRGA Worceste If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 11–27–1932 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. 1 X M 2 □ F Months Days Hours 179-26-5099 76 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No SUSSEX DELAWARE MILLVILLE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 31446 OAK STREET 19970 IIS 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XiYes 2 ☐ If Yes, Give Year or Dates; 1 ☐ Yes 2 No 50-52 Specify Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVICE TECHNICIAN **SEARS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES THOMAS ANNA STEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA J. GRANT/ DAUGHTER 1209 HARPER AVENUE, WOODLYN, PA. 19094 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Semation 3 ☐ F 4 ☐ Donation 5 ☐ Sther (Specify) 3 Removal from State MELSONS CREMATORY 11-6-2009 FRANKFORD, DELAWARE 21. Signature of Functal St MELSON FUNERAL SERVICES, LTD 38040 MUDDY NECK RD, OCEAN VIEW, DE. 19970 23a. Part L Enter the Tise shock, or heart fixed or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) honic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown own

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show the Medical Exeminar must be nutified at

Director

Funeral

Completed by

Be

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within 72 hours after death with the Maryland

12 should be filed within the and Mental Hygiene.
7 is marked other than '

1 and 2 should be Health and Mental

Injury or other traumatic

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

=15)00

Examiner

the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, p an 24 hours the Funeral Dire

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Medical

Part II. Other significant condition	ns contributing to death but not re	sulting in the underlying	g cause given in Part I.		use contribute to the cause of death	
				24a. Was an autopsy performed?		
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
1 Yes 211 No	Hospital: 1541npatient 2	☐ ER/Outpatient 3 ☐	me 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death  1 S Natural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		nome, farm, street, factorify)	ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)	
29a. Certifier 1 Gertifying (Check only one) 2 Medical Expension	i Physician: To the best of my kn xaminer: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occi	I e, and due to the cause(: urred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)	

29c. License number

0050826

Drive Belin mo

29d. Date signed (Month, Day, Year)

DH 6+1

To the Hosl within 24 ho To the Functional

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAZAM Engla 1733 HEADE 31. Date filed (Month, Day,

29b. Signature and title of certif

32. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HOMAS NIYAH Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SO. MD. HOSP. CENTER MARYLAND PRINCE GEORG INTON 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day g. Birthplace (State or Foreign **Funeral** Min. Months Hours NONE **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country, Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 item 27 is marked other than "natural", other traumatic event, the Medical Exal Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) INFANT NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i JASMINE THOMAS-MOTHER 3200 CURTIS DRIVE TEMPLE HILLS, MD. 20748 Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

1 □ Burial 2 □XCremation 3 □ Removal from State TROPOLITAN CREMATORY 11-21-09 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot ALEX., VA. M00479 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respirator Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death WW Physician, disease or condition resulting in death) Medical Due to (or an a consequence of **€**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to fr as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death Pregnant at time of death in the past 12 months? Year Month Day g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ ER/Outpatient 3 DOA 1 XInpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔏 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VERGARA

1503 SURRATT RD.

D34302.

CUNTON, MD. 20735

onald Lee Viole	1	1- For State Certific	nent of Health and Mental Hy cate of Death	ygierie Reg. No.	2009 3772
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)  Ronald Lee Violet		2. Date of Death Month Day Ye October 31, 2009	3. Time of Death 1800 hrs
ledical Examir		Ronald Lee Violet  4a. 17865 Aame (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County	
		17854 Canal Road	Smithsburg Sharpsh		
Funeral Director		5. Social Security Number 215–44–9783 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	<del></del>	Foreign
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	vn or Location		10d. Inside City Limits
	٦	Maryland Washington Sh	narpsburg	La cui	1 X Yes 2 No
Maryl rr 28a-1	Φl	10e. Street and Number 17865 Canal Road	10f. Zip Code 21782	10g. Citizen of V	1
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Rac	ce - American Indian, Black, lite, etc.
r death or iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	1 Yes 2 X No specify:	Specify	
ars after tural", aminer	<u>a</u>	3 Widowed 4 Divorced of Paragraph 15. Decedent's Education (Specify only highest grade completed) 16	a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of I	Business/Industry
6 172 hou an "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret		1
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	mo.	17. Father's Name (First, Middle, Last)	Professor 18.Mother's Nam	e (First, Middle, Maiden Surnan	.lege
215 be file intal Hy rrked o	Be	Paul Edward Violet		en Emma Rice	State Zin Code)
MD 21 Id 2 should Ilth and Me m 27 is ma aumatic ev		19a Informant's Name/R <b>Righthafi</b> 19pe, P <b>Executor</b> Michael S. Rusman / Exectuor	19b. Mailing Address (Street and Number or 606 Wyngate Drive	Frederick, Mar	
e, M 1 and 2 Health item 2	ŀ	20a. Method of Disposition 20b. Plac	ce of Disposition (Name of cemetery, matory or other place)	Date 20c. Locatio	n - City or Town, State
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other Specify:	ffer Crematory 11-		rick, Maryland
Balti permit. Departi Import injury		21. Signature of Funeral Service Lice See	22. Name and Address of Facility Ba		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or	heart Approximate Interval Between Onset and
M. dical xaminer	9	Immediate Cause (Final disease a. Contact Gunshot Wound	of Head		Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	iner	if any, leading to immediate Due to (or as a consequence of):			
ed ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
(68760, certificate be executed maling physician and use as the burial - transit		UNPENDED #4a,28f,per M	rME,#19a,perFH,G899,1/21/2 E g8 <b>9</b> 8 12/2/09 TT	010,WS	
760, icate be physic the bur	/Mec	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the	ncy 2 Estacio progr	23d. Date	e of delivery n Day Year
ox 6876 eath certificate attending phy for use as the	Physician/Medical	past 12 months?  4 Pregnant at time of death	Z Total abatil		
). Box the death c by the atten	Phys	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.		ontribute to the cause of death?
P.O.	by				3 Probably 4 Unknown
of Vital Records, Pag Physician: The law requires t After this certificate has been sign nneral director, page 2 should be c	Completed			24a. Was an 24 autopsy performed?	b. Were autopsy findings available prior to completion of cause of death?
tal Reco	Com		26 Place of Death (Chec	1 Yes 2 ✔ No	1 Yes 2 No
Vital ysician: his certil	Be	examiner?	lou		6 Other: Scene
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death. within 24 hours after death. The Person of the Attendent Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for u	n: To	27. Manner of Death  1 Natural 5 Pending FOUND: 28a. Date of Injury Programme Programm	8b. Time of Injury 28c. Injury at Work?  OUND: 28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe how injury oc Subject shot self	curred
Division tal or Attendi rs after death.	Certification:	2 Accident Pending Oct 31, 2009 1 28e. Place of Injury - At hom	1750 hrs ne, farm, street, factory, office building, etc.	28f Location (Street and No	umber or Rural Route Number, City
Divi spital or cours afte reral Dir filled in	Sertif	3 ✓ Suicide 6 Could not be determined (Specify) Single Famil			umber or Rural Route Number, City <b>PSDUTE</b> Hoburg, MD
To the Hospital within 24 hours To the Funcral completely fille			, death occurred at the time, date and place, a l/or investigation, in my opinion, death occurre	ind due to the cause(s) and mai d at the time, date and place, a	nner as stated. nd due to the cause(s)
To the within 2 To the complete	Medical	and manner stated.  290. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
		() (an (akell)	O.C.M.E.	Novemb	oer 1, 2009 
611		30. Name and address of person who completed cause of death (Item 2 Laron Locke MD. Assistant Medical Examiner	(3a) 111 Penn Street, Baltimore, MD 2	1201	
3H-6	tate	A Company Comp			
Reais			7 /20 /24 /CA		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ALTER Month **Physician** 450CICI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 153 Cardamon Drive Edgewater If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 05/18/1926 9. Birthplace (State or Foreign 5. Social Security Numbe 353–12–4049 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F Months Days Hours Min Illinois Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h. County 10d Inside City Limits of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinant he notified at 10a State 10c. City. Town or Location 1 ☐Yes 2X No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 United States 153 Cardamon Drive Funeral 12. Was Decedent Ever in U.S. Avmed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 □No If Yes, Give RETIRED Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lt. Commander United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecilia Schweda Walter K. Wysocki ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 153 Cardamon Drive, Edgewater, Maryland 21037 Mary Ann Wysocki/Wife Department of Heal Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐Other (Specify) 11/03/2009 | Edgewater, Maryland 4 Donation Kalas Crematory 21. Signatur Fur rai Seulo, io nse 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Pert1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme Te Cause (Final Physician NUCO disease or condition resulting in death) /Medical Due to (or as a const uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 No 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending e Hospital or AttendIn 124 hours after death. e Funeral Director: Af investigation 1 ☐Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar ame and address of pe

31. Date filed (Month, Day, Year)

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rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A Facility Name of not himthon, special contents.  Anne Arrunded Medical Center  Total State Medical Center  Total State Medical Center  Total State Medical Center  Total Medical Center  Tot	1. Decedent's Name (First, Middle, Last)   2. Date of Death Month   Day Year   November   2, 2009	lel  place (State or For								
Vivian A   Williams   Wilder	Vivian A. Williams  4a. Facility Name (If not institution, give street and number)  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Anne Arundel Medical Center  5. Social Security Number  267-52-1071  Usual Residence of Decedent  10a. State  10b. County  MD  Anne Arundel  Crofton  Anne Arundel  Crofton  Month  November  2, 2009  4c. County of Death  Anne Arunde  4c. County of Death  Anne Arunde  4c. County of Death  Anne Arunde  4c. County of Death  Anne Arunde  Feb. 8, Date of Birth (Month, Day, Year)  (Month, Day, Year)  Feb. 8, 1920  Ill.  MD  Anne Arundel  Crofton  10c. City, Town or Location  10f. Zip Code  10g. Citizen of What County  10g. Citizen of What County	lel place (State or For inois								
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Specific   Specific		can Indian,								
Specific   Specific	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, et 1 Never Married 2 Married 1 Yes 2 XNo	etc.								
16a.   Decederate Status Conception   16b. Kind of Businesse Industry	If Yes, Give 1 □ Yes 2 ☑ No Specify: Specify: 7	White								
Roof Remarks Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maidden Summan)   18. Mother's Name (First, Middle, Maiddle, Maidden Summan)   18. Mother's Name (First, Middle, Maidden Summan)   18. Mother's Name (First, Middle, Maiddle, Maidd		dustry								
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Roof Remarks Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maidden Summan)   18. Mother's Name (First, Middle, Maiddle, Maidden Summan)   18. Mother's Name (First, Middle, Maidden Summan)   18. Mother's Name (First, Middle, Maiddle, Maidd	Elementary/Secondary (0-12) College (1-4or 5+)  Page stored Nurse Healthcare He	(ospital								
Roy A. Andrew    Page   Informatis NameRelationship (Type Print)   19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code)		ODPICAL								
19a. Informant's Name-Relationship (Type Pint)  Lee E. Williams/Son  20a. Method of Dispose Licenses  10 Bard 2 Schemation 3 Removal from State 10 Bard 2 Schemation 3 Removal from State 10 Bard 2 Schemation 3 Removal from State 10 Bard 2 Schemation 3 Removal from State 11 Bard 2 Schemation 3 Removal from State 12 Schemation 3 Removal from State 12 Schemation 4 Schemation 4 Schemation 5 Removal from State 13 Baytiew Crematory 11/4/2009 Baltimore, Maryland 21. Signature of Funcil Separate Licenses  22. Name and Address of Facility Beal I Funceral Home 6512 NW Crain Hwy., Bowie, MD 20715  23a. Part I. Enter the disease, or complication that caused the death. Do not not neither the mose of dying, such as cardiac or respiratory arrest.  Prince the disease, or complication that caused the death. Do not neither the mose of dying, such as cardiac or respiratory arrest.  Prince the disease, or complication that caused the death. Do not neither the mose of dying, such as cardiac or respiratory arrest.  Prince the disease, or complication that caused the death. Do not neither the mose of dying, such as cardiac or respiratory arrest.  Prince the disease, or complication that the death of the de	m Danie Markey dan									
The E. Williams/Son   1859 Kings Place, Crofton, MD 21114	e Roy A. Andrew Emma Mackender									
Date   Description   Descrip	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	Code)								
Total   Continued   Continue	Lee E. Williams/Son 1859 Kings Place, Crofton, MD 21114									
Bayview Crematory   11/4/2009   Baltimore, Maryland	cometery cramatory or other place)	wn, State								
22. Name and Address of Facility  Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715  23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Accordinate intervitation of the computation o	1 L Burial 2 LX Cremation 3 L Removal from State 1	larvland								
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23a. Part I. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (finding) and the condition resulting in death)  Due to (or as a consequence of):  Due	beall ruleral nome									
Sequentially list conditions, and the sequence of the sequence										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death   1   Yes   2   No   3   Probably   4   No.	resulting in death)  Sequentially list conditions, it ally a consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Du to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy findings ava prior to completion of cause death?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Were autopsy findings ava prior to completion of cause death?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   1   Yes 2   No 3   Probably 42 Nnk   24b. Was an autopsy performed?   24b. Was an autopsy pe	FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   Month   23d. Date of delive   Month									
25. Was case referred to medical examiner?  1	A Land Control Significant Control and the Con									
25. Was case referred to medical examiner?  1	Altered Mental Status,  24a. Was an autopsy performed? performed? performed?	y prior to completion of cause oned? death?								
examiner?    Second		2 🗆 140								
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifier (Check only one)  29b. Signature and this decider.  29b. Signature and this decider.  27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28c. Place of Injury - At home, farm, street, factory, office  28d. Describe how injury occurred  28d. Describe how injury occu	examiner?	7.1								
29a. Certifier (Check only only 1)		у)								
29a. Certifier (Check only only 1)	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)	al Route Number,								
29b. Signature And this of contiller 29c. License number 29d. Date signed (Month, Day, Year) 11-2-700?										
		Day, Year)								
	DAMA 1 1-2-7	009								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  STEVEN HAMLETTE, MID, ZOUL Medical Parkway, Anapolis, Md 2140  at 31. Date filed (Month, Day, Year)  32. Registrar's Signature										
e 31. Date filed (worth, Day, Year) 32. Heinstrars Signature	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  STEVEN HAMLETTE, MID, 2001 Medical Parkway, Anacpolis, Mc	1 2140								
	31. Date filed (Month, Day, Year)  32. Registrar's Signature  NOV 0 5 2009									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Wayman PM **Physician** 2009 November egina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner to(D, tal Ba Ih more Cit If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours 1 □ M 2 1 F Yrs. 192-52-3272 Feb. 28, 1961 Delaware Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County show is 23a or 28a-f sho 1 XYes 2 No Director Maryland Caroline Greensboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21639 Funeral 702 Harold Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Yes Give Completed by 3 ☐ Widowed 4 ☐ Divorced Black. Year or Dates "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linwood Harrison Warner Gloria Wayman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2403 Perrysville Ave., Apt. 406. Pittsburgh, PA15214 L. Harrison Warner/father permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.14,2009 Cokers Cemetery Greensboro, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** etast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to man or late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) signed by the sid be detached for P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No 2 No this certificate 1 ☐ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ finpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after users. the Funeral Director: After this of anietely filled in by the funeral di ٩ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide completely filled 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KES-000 november 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vandana 600 N. Wolfe St. Baltimore, MO 21287 alaq 32. R gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	Registrar			Ce	rtificate of	Death		Reg. No.2	009	311
ın	1. Decedent's Name (First, Middle	e, Last)					Date of De     Month	ath Day	Year	3. Time of D
al	LESTER JA	MES WE	ELLS,	III			10	31	2009	
er	4a. Facility Name (If not institution					r Location of Deat			unty of Deat	
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		6. Sex 7	'. Age (In yrs. I	ast <i>birthday)</i> Yrs.	Months Days	Hours Min.	(Month, Da	y, Yea <i>r)</i>	Co	ountry)
	Usual Residence of Decedent		55				NOV 17,	1955	GUMI	BORO, DE
	10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City
to	DELAWARE SUSSEX	X COUNTY	мттл	LSBORO	1					1 □Yes 2
irec	10e. Street and Number	A COUNTY	111111	BODORO	10f. Zip Code			10g. Citizer	n of What Co	ountry?
<u>=</u>	22631 DAISEY RD.	(GUMBORO	0)		19966			UNITE	D STAT	TES
Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	- 14.		erican Indian,
	1 ☐ Never Married 2 🙀 Marri	ied Armed Forc	2 🔽 No		If Yes, specify Cuba		io nicari, etc.)		Black, White	
þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	tes:		1 □Yes 2 <b>1</b> No	Specify:		Sp	pecify: WH	ITE
Completed	15. Decedent (Specify only highes	t's Education		16a. Dece	edent's Usual Occup	oation during most of wo	rkina	16b. Kind	of Business/	Industry (Industry
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å	17. Father's Name (First, Middle, I	Last)					me (First, Middle,			
ဝ	LESTER JAMES	WELLS, JE	R.			ELVA M		ISHER		
	19a. Informant's Name/Relationsh			1	ing Address (Street					Zip Code)
	DEBORAH HOLLAND	) WELLS			1 DAISEY	KD. MILL				
	20a. Method of Disposition 1 M Burial 2 ☐ Cremation	3 □ Removal from St	1 0	lace of Dispo emetery, cre	osition (Name of matory or other plac	сө)	Date	20c. Locat	tion - City or	Town, State
	4 □ Donation 5 □ Other (St		DA	ALE CE	METERY	NOV	5, 2009	WHAL	EYVILI	E, MD
	21. Signature of Funeral Service I	Licensee/ /		2	2. Name and Addre	ess of Facility				
	Atkinin	Act	~MO 13	161	TAMOON DIT			DAY 1	25 MTI	T CRADA
10	23a. Part 1, Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	our lications that cal only one hause on each a.  Due to (o	used the death	h. Do not en	ater the mode of dyin	factu	c or respiratory a			Approximate Interval Betw Onset and De
i Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (of	used the death ch line.	Do not en	ater the mode of dyin		c or respiratory a			Approximate Interval Betw
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Frances V. Webber 2009 5:00 Α November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Vindobona Nursing Home Braddock Heights If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 17, 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🟋 F 217-20-5763 84 Yrs. 1925 **Director** Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ihw Multical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Directo Frederick Maryland Brunswick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21716 1100 Peach Orchard Lane, Apt. 103 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo \$ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School System 11 Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Price Genevieve Noose ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5107 Ella Court, Jefferson, MD 21755 Keith Webber / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Stauffer Crematory 11/5/2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 all 23a. Pa Enter the dise regri complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Unit only one cause on witch line. Approximate Interval Between nset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed nding physician and se as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant sate has been signed by the atter page 2 should be detached for u 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death 1 □Yes 2 ☑No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 □Yes 2 🖾 No 1 ☐ Yes 2 ☐ No s after deau...
ral Director: After this con...
- In by the funeral director, pe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

NINTH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Chron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended#23perMD FCHD,KS Certificate of Death 11/6/09 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** JANICE WATKINS 2009 12:35 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 218-52-9764 60 October 7,1949 Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 1 ☐ Yes 21 No Director Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12536 Quiet Stream Court 21771 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Examiner Health Insurance Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fill Health and Mental Hem 27 is marked otl Morris Eldridge Jerrell ဂ္ Roy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any Injury or other tr once. Gary L. Watkins / Husband 12536 Quiet Stream Court/Mount Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Garden Nov. 6, 2009 | Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike/Frederick, Maryland 21702 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cutise (Final Pulmonary Embolism Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner adenocarcinom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 🏋 No Ö the 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2**X** No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1, npatient Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Control of the Funeral Dir

of Vital Records, Division

10

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

IN

Year

Medical

MUT

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

09-08877 Kenneth Williams

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate	of Death	Reg. No. 2009 37	171
Physici	ian	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year November 15, 2009  3. Time of Death 1259 hrs	h
cai Exaiii	IIIIE	Kenneth Daniel Williams  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
		Johns Hopkins Bayview Medical Center	Baltimore	Baltimore County	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 217–70–7899 1 X M 2 F 51	Yrs. If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Puer Mar. 19, 1958 Country) Rico	to
any	]	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ocation	10d. Inside City	Limits
*	١,	Maryalnd Frederick Monrovia		1 Yes 2	X No
faryla 28a-f Lator	1 2	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
ith the Maryland 123a or 28a-f show a notified at once.	غُ	12514 Sandra Lee Court	21770	USA	
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		k,
fter de	ن ا		Yes 2 X No specify:	Specify: White	
ours a	7	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kind of wing most of working life. DO NOT use retire		
be filed within 72 hours after tal Hygiene. ked other than "natural", out, the Medical Examiner	1 2 2	Elementary/Secondary (0-12) College (1-4 or 5+)	·	Automotive Glass	
d withing giene	8	12 Dist	rict Manager 18.Mother's Name	Replacement Compa (First, Middle, Maiden Surname)	.ny
uld be filed Mental Hyg marked oth c eveut, the	3	Joseph Samuel Williams		dna Brouse	
hould nd Me is ma	F	19a. Informant's Name/Relationship (Type, Print )	ailing Address (Street and Number or F	tural Route Number, City or Town, State, Zip Code)	
permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev			14 Sandra Lee Cour	t, Monrovia, Maryland 21 Date   20c. Location - City or Town, State	<u>770</u>
ges I a of He Ifite		1 Burial 2 X Cremation 3 Removal from State crematory of	or other place)		
it. Pag rtmeni ortant		4 Donation 5 Offer Specify Metropol 21. Signature / Funeral Service License	itan Crematory 11/	18/2009 Alexandria, Vi <u>rgi</u> esworth-Williams Funeral	nia
perm Depa Impo injur				Damascus, Maryland 20872	
nysician		23a. Part Enjer the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart Approximate Between Ons	Interva
Medical kaminer		Immediate Cause (Final disease a. Subarachnoid hemor	rhage	Death	1
	ı	or condition resulting in death)  Due to (or as a consequence of):  Begunnially list conditions  Due to (or as a consequence of):	urvem		
	į	Sequentially list conditions,	Luly om		
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
outed nd ransit	وُ ا	d.			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	1 5	MENDED  AMENDED  PI line a-b  AND AMENDED  PI line a-b  AND AMENDED  AMENDED  PI line a-b  AND AMENDED  AMENDED  PI line a-b	, 27, per ME g898	12/2/09 TT	
ficate by physical pure for the but	1	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery	ear
h certif lending use as		past 12 months?  Pregnant at time of death  5	Fetal death 3 Ectopic pregna Other (Specify)	World Say	Jui
e deat the at ed for	3	5 a la la la la la la la la la la la la l			-450
ires that the death certific signed by the attending I be detached for use as t	3	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de  1 Yes 2 No 3 Probably 4 ✔ Uni	
w requires us been sig should be	3			24a. Was an 24b. Were autopsy findings a	
cian: The law requi certificate has been ector, page 2 should				autopsy prior to completion of ca performed? death?	
r. The ifficate or, pag.	8		26.Place of Death (Check	1 Yes 2 No 1 Yes 2 Only one)	No
ysician: The his certificate director, page	٩	to examiner?  O 1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient 2 ER/Outpa	[Other:	ng Home 5 Residence 6 Other:	
ling Physi After this funeral dir	l F	27 Manner of Death 28a Date of Injury 28h Time	e of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ttendi death rtor: / / the fi	{	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No		
I or Attend after death Director: d in by the		1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, (Specify)	street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Numb or Town, State)	er, Cit
To the Hospital or Atteuc within 24 hours after death To the Funeral Director: completely filled in by the			accurred at the time, date and place, and	due to the cause(s) and manner as stated.	
the H hin 24 the Fu	. 3	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	stigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)	
To Wit Con	100	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
		Carol Hallan	O.C.M.E.	November 17, 2009	
7		30. Name and address of person who completed cause of death (Item 23a)			
			nn Street, Baltimore, MD 2120	17	
9	Sta	te 31. Date filed (Month, Day, Year) ar NOV 2 4 2009	30 Ked		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day James Zimmerman 3:00 A 2009 November 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 14980 Potomac River Drive Charles Cobb Island 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under: Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Min. 475-64-5489 58 1951 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No Maryland Charles Cobb Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14980 Potomac River Drive 20637 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 Mo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th. Vice President Technical Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Laverne Zimmerman Mary Janet Elias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zachary Zimmerman/ Son 7365 Sandy Bottom Ct. Hughesville, MD. 20637 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery Jan. 4, 2010 Arlington, VA. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licens 3035 Old Washington Rd. Waldorf, Maryland, 20601 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw 23a, Part 1. Enter the disease, or complicati shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

Examiner that the death certificate be executed burial-tran physician s the burial Box 68760. as attending nse for P.O. the signed by t t be detach of Vital Records, page certificate funeral director, After this Division or Attending n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fur filled in by Hospital Medical within 2

Examine Physician/Medical þ Completed Be မှ

Certification:

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exprinent must be notified at

**Physician** /Medical

Baltimore, Maryland 21215-0036

/Medical

2 Accident 6 ☐ Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. WISOM 2070

31. Date filed (Month, Day, Year) 4 2009 32 Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ .10 2009 Carole Albright Nov Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arunde1 Pasadena Anne 3503 Wedgewood Court 8. Date of Birth (Month, Day, Jan, 10 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** New Jersey Days 1 🗆 M 2 🕱 F Jan, Director 076-26-7936 Usual Residence of Decedent 10d. Inside City Limits shov 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3503 Wedgewood Court United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2X No Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Yes. Give "natural", 3 Widowed 4 Divorced White Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Government** Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Cornig Aslanian Gladys Bjurstrom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14625 Southeast 45th Street, Bellevue, Washington 98006 Hardesty/Daughter Kathryn 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 23. t of := : 1 Burial 2 K Cremation 3 Removal from State Important: Is any injury or Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryalnd 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a 1 nsequence of): Physician/ Medical resulting in death) Examiner lure to Thri Sequentially list conditions, Due to or as a consequence of) Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Day Month in the past 12 months? Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of filled in by the funeral 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: After t work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie November 23, 2009 65548 Julie Alolodonah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P Edwar Faynor Blva. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

09-09023	
Sharon Albert	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Sharon Albert		1-For State State of Maryland / Depart	tment of Health and Mental ficate of Death		No. 2009 377
Physici Medical Exami		Decedent's Name (First, Middle,Last)		2. Date of Death Month I November 2	3. Time of Death
(		4a. Facility Name (if not institution, give street and number) 617 Waterwheel Lane Apt 13	4b. City, Town, or Location of D Millersville, MD		4c. County of Death Anne Arundel
Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last   0.54 - 52 - 4411   1	birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. Aug. 1	MM/DD/YYYY) 9. Birthplace (State or Foreign country)District of Columbia
d low any		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location rsville		10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show any motified at once.	Director	10e. Street and Number 617 Waterwheel Lane, Apt. 13	10f. Zip Code 21108	_	Citizen of What Country?
2. FT7 FEFFE 3. MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f short rammatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - American Indian, Black, White, etc. Specify: White
7 (36 M) 3036 within 72 hours after tene. er than "natural", C	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  4	6a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use Homemaker	of work done 1 retired)	16b. Kind of Business/Industry Own Home
21215-0036 21215-0036 Montal Hygiene. marked other than it event, the Medical	Be	17. Father's Name (First, Middle, Last)  Joseph Albert	18.Mother's N Evelyr	ame (First, Middle, Ma 1 Darby	aiden Surname)
MD 21  MD 21  and 2 should ealth and Me em 27 is ma rraumatic en	င္		19b. Mailing Address (Street and Number 55 Spires Gardens, Winwicce of Disposition (Name of cemetery,	ck, Warringto	
SHEAL FT HE BETURY  Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death without of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other transmatic event, the Medical Examiner must be		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. S na e of Funeral Service Usensee	matory or other place) ro Crematory  22. Name and Address of FacilityC1	lov. 27, 2009 cemation So	Baltimore, Maryland
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	o not enter the mode of dying, such as cardi		ore, Maryland 21228  tt, shock, or heart Approximate Interval Between Onset and Death
( ¬xaminer	Į.	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  a. Atherosclerotic Cardiovas Due to (or as a consequence of):  b. Due to (or as a consequence of):	Scular Disease		
ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760, Trate be executed physician and the burial - transit	_	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregna	ncy		23d. Date of delivery
Box 687 e death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  1  Live birth 4  Pregnant at time of death 9  Unknown	2 Fetal death 3 Ectopic pri	egnancy	Month Day Year
ls, P.O. quires that the en signed by	þ	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	1Yes	acco use contribute to the cause of death?  2 V No 3 Probably 4 Unknown
Recorc: The law red ficate has bed; page 2 shou	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n: To Be	27. Manner of Death  28a. Date of Injury (Month, Day, Year)	8b. Time of Injury 28c. Injury at Work?	ursing Home 5 R	esidence 6 Other: Scene
Division tal or Attend rs after death. al Director:	Certification:	Accident Suicide 6 Could not be determined (Specific)	e, farm, street, factory, office building, etc.		reet and Number or Rural Route Number, City ste)
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.			
<b>A F S F S S S S S S S S S S</b>	Ĕ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year)  November 27, 2009
St	ate	Name and address of persor who completed cause of death (Item 23 Jack Titus MD. Deputy Chief Medical Examiner     Deputy Chief Medical Examiner     31. Date filed (Month, Day, Year)	111 Penn Street, Baltimore, MD	21201	
Regist	trar	NOV 3 0 2000	A Barrell		
DHMH 17 Rev 1/20 OCME 2006	UU 1		ORIGINAL		OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rystai L. Angie	53	State of Maryland / D 1-For State Registrar	Certificate of			9. No. 200	9 3773
Physic Medical Exam		Decedent's Name (First, Middle,Last)			2. Date of Death Month November		3. Time of Death 2001 hrs
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		St. Agnes Hospital		Baltimore		Ba	altimore City
Funeral			yrs. last birthday)	If Under 1 Year If Und Months Days Hou		h(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		217-02-4726 1 M 2 VF	31 Yrs.			ec 31, 1977 Co	untry) MD
any			c. City, Town or Location	on			10d. Inside City Limits
Maryland 28a-f show d at once.	i	MD Baltimore		Ha	alethorpe		1 Yes 2 No
e Mary	Director	10e. Street and Number 4704 Leeds Ave.		10f. Zip Code	21227	g. Citizen of What Cou	ntry? U.S.A.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho manite event, the Medical Examiner must be notified at once.	la D	11. Marital Status 12. Was Decedent Eve	erzin U.S. 13. Was	Decedent of Hispanic Or	rigin? ( Specify Yes or No-		ican Indian, Black,
death or item	Funeral	1 Never Married 2 Married Armed Forces?	No If Ye	s, specify Cuban, Mexica	in, Puerto Rican, etc.)	White, etc.	. 1
		3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No specifi		Specify: (16b. Kind of Business/	ute
2 hour	eted	15. Decedent's Education (Specify only highest grade complet  Elementary/Secondary (0-12) College (1-4 or 5+)		s Usual Occupation (Given st of working life. DO NO		16b. Kind of Business/	industry
036 rithin 7 sne. rr than	Completed	12		Secret	tary	Cleric	al Healthcare
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after men of Health and Mental Hygiene.  tent: If iten 27 is marked other than "natural", or other traunnafic event, the Medical Examiner.	ပိ	17. Father's Name (First, Middle, Last)  Harry Lee Ang	ıles .lr	18.Moth	er's Name (First, Middle, M	<sup>(</sup> aiden Surname) <b>Denise Ann All</b> e	an l
212 ould be Menta mark	o Be	19a. Informant's Name/Relationship (Type, Print )		Address (Street and Nu	ımber or Rural Route Num		
MD d 2 sho lith and m 27 is		Denise Angles Mother			tt City, MD 21043		
or Heal		20a. Method of Disposition  1	20b. Place of Disposi crematory or oth	tion (Name of cemetery, er place)	Date	20c. Location - City or	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is in jury or other traumatic.		4 Donation 5 Other Specify: 2 Superture of Fusing Trail Service Lice see		w Memorial Park ame and Address of Facil	Nov 23, 200	9 Sykes	ville, Maryland
Balt permit. Departr Import		Allow Barrents Out 400	793	Slack Funera	al Home, P.A. Iumbia Pike Ellicot	t City. MD 21043	
Physician		23a. Part Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter th	e mode of dying, such as	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Methadone  Due to (or as a conseque		yl intoxica	tion		Death
		Sequentially list conditions,  b	ence or).				
	iner	if any, leading to immediate cause. Enter Underlying Cause	ence of):				
S G LO	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence)	ence of):				
iox 68760, eath certificate be executed attending physician and for use as the burial - transit	cal	XUNPENDED AMENDED 22					+
'60, ate be a ohysicia	Medical	IF FEMALE: 23c. If yes, outcome of	7,28a-f,pe	rmE, g898 1	2/11/09TT	23d. Date of deliver	у
687 certific nding p	cian/I	23b. Was decedent pregnant in the past 12 months?	o of dooth		pic pregnancy	Month	Day Year
Box e death the attered for u	Physic	1 Yes 2 No 9 V Unknown 9 Unknown	e or death 5 Oth	er (Specify)			
ires that the d signed by the 1 be detached	by PI	Part II. Other significant conditions contributing to death but	it not resulting in the u	nderlying cause given in I		bacco use contribute to	the cause of death?
rds, F requires been sign	ted				1 Yes		utopsy findings available
cords, law requir has been s	Completed				autop perfor	sy prior to death?	completion of cause of
tal Rec cian: The certificate ector, page		25. Was case referred to medical		26 Place of Deat	1 ✓ Yes :	2 No 1 Y	es 2 No
Vita hysician this cer 1 direct	o Be	examiner?	2 🗸 ER/Outpatient	Othor		Residence 6 Othe	er:
1 Of ling Ph After I	l Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	· ·   _ · · -		now injury occurred	
Sior Attend r death ector: by the	catic	2 Accident Pending Investigation Pending Investigation Representation Pending Investigation Representation Pending Investigation Representation Representation Pending Investigation Representation Pending Investigation Representation Pending Investigation Representation Representation Pending Investigation Representation Pending Investigation Pending	09 Fd 1911	hrs 1 Yes 2.		Street and Number or R	ural Route Number, City
Divis pital or At ours after d teral Direct filled in by	Certification:	Suicide V X Could not be	idence	t, ractory, onice building,	_ or Town, S		955
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my kn	-		place, and due to the caus	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated.	ation and/or investigat	on, in my opinion, death		and place, and due to the 29d. Date signed (Mo	
	=	29b. Signature and title of certifier		O.C.M.E.	J.	November 18, 2	
1		30. Name and address of person who completed cause of deal	h (Item 28a)		··		
Ψ		Zabiullah Ali, M.D. Assistant Medical Exam		n Street, Baltimore,	, MD 21201		
S Regis	itate strar	31. Date led World, Day 2009 32. Registrar's S	Signature	,			
			7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ATKINSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore

a Rirthplace (State or Foreign Season's Hospice Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace Country) Days Min 1 □ M 2**X**□ F Months Hours Director 89 214-01-2192 Jan. 1920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exeminar must be notified at Director 1 ∐ Yes 2 DXNo MDAnne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or filed within 72 hours after death with 306 Jerlyn Avenue 21090 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🌠 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Cox Ada (unknown) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. 306 Jerlyn Ave., Linthicum, MD 21090
20c. Location - City or Town, State <u> Jean L. Matthews - Daughter</u> 20b. Place of Disposition (Name of MD Veterans Cemetery Genetery) (a Crewnsville 20a. Method of Disposition 1 Nourial 2 Cremation 3 Removal from State 4 □ Qonation 5 □ Qther (Specify) 11-23-2009 Crownsville, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. al In Funeral Service Licensee 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CREBRAC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. ned by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔊 Unknown completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 2 🗆 No 1 □Yes 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)
Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury loccurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 29c. License number

V

State Registrar 31. Date filed (Month, Day, Year)

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10000



283

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ам Germaine L. Attebery 16, 2009 9:08 /Medical <u>November</u> 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Director 435-62-7875 Nov. 4, 1944 Louisiana Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1X Yes 2 □ No Maryland | Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 102 Virginia Avenue 20850 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 📉 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 0wner Catering Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleone Robert Lalanne ပ Margarite Weil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau David W. Attebery/Husband 102 Virginia Avenue, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. November 23, 4 Donation 5 Other (Specify) 2009 Bethesda, Maryland 21. Signatur & Funeral Service Lice 22. Name and Address of Facility bert A. Pumphrey Funeral Home /Rockville, Inc. 11. lan M01530 BOO West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stare Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify)Hospice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading the date and place and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koueltcheu, MD D 63748 November 16, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Jocelyne Kouatchou, M.D.

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21218

201 East University Parkway

32. Redistrar's Signature

the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. within 2 To the

To the Funeral Director: completely filled in by the

Medical

29b. Sig

Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year State Registra

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 25, 2009

30. Name and address of person who completed cause of death (Item 23a)

and title of certifie

09-09133 Brial Bowser

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brial Bowser		- For State	ate of Maryland		rtment of tificate of		Mental H	_	g. No. 2 C	000 077
Physician	1/	Registrar  1. Decedent's Name (First, Middl						2. Date of Death	2.0	9. Time of Death
Medical Examine		4a. Facility Name (if not institutio	Bowser on number)		14	b. City, Town, or L	ocation of Death	Month November	24, 2009 4c. County of Dea	0729 hrs
	ı	2644 Lauretta Avenue	-			Baltimore			N/	A
Funeral	7	5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_ ,	(MM/DD/YYYY) 9. B	
Director	1	·	1 M 2 F		Vrs.	2 0	Hours Will	Sept. 2		country) Maryland
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	./.	10c. City,	Town or Location	on D II.				10d. Inside City Limits
. ≰	5	Maryland 1	NA			Battin	rore			1 Yes 2 No
eath with the Maryland items 23a or 28a-f show	Director	10e. Street and Number	sta Ave.			10f. Zip Code	1377	10	g. Citizen of What Co	untry?
ith the	<u>=</u>	11. Marital Status	12. Was Decedent	Ever in III	2 13 Was	Decedent of Hisp	anic Origin? / S	posify Ves or No.	114 Page - Ame	erican Indian, Black,
eath w	Funeral		arried Armed Forces?			es, specify Cuban,			White, etc.	
after craft, or	<u>~</u>		orced If Yes, Give Year or Dates:			Yes 2 No			Ѕреслу:	ack
2 hours "natu	E -	15. Decedent's Education (Specific Elementary/Secondary (0-12)	cify only highest grade con College (1-4 or			's Usual Occupationst of working life. I			16b. Kind of Business	s/Industry
5-0036 led within 72 Tygiene. other than the Medical	Completed	0		,		MA			NIU	
filed w Hygie d other	3	17. Father's Name (First Middle,	· ·	<u>.</u>			1 4	e (First, Middle, M Thomp	,	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	10 Be	CINTON BOWS  19a. Informant's Name/Relations			19b. Mailing			/	ber, City or Town, Sta	ite, Zip Code) 21227
MD d 2 sho lth and n 27 is		Katna Thom		er	2644	- Laur	etta A	ve. Bo	altimore	Maryland
ore, MC ss 1 and 2 s of Health a If item 27		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from St	ate 🗼 c	rematory or oth		etery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I al Department of He Important: If ite	-	4 Donation 5 Other St	pecify:	Art		Memorial	Park 11	130/09	Arbitus	Maryland
Balt permit. Departi		21. Signature of Funeral Service	Harke-		22. N	ame and Address	of Facility Par	Kertune	ral Home	aryland
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that caused	the death.	Do not enter th	e mode of dying, s	uch as cardiac	or respiratory arre		pproximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease	a Sudden ur			eath in :	infancy	(SUDI)		Death
/	1	or condition resulting in death)	Due to (or as a cons	equence of	):					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of	):					
14 =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of	):					
50, te be executed ysician and burial - transit	<u></u>	ΓV	d.		<del> </del>					
te be ex ysiciar burial	ledical	X UNPENDED  IF FEMALE:	AMENDED 23a			rm,E g899	9 1/29/	lo TT	23d. Date of delive	200
Box 68760, e death certificate be the attending physic ed for use as the bur		23b. Was decedent pregnant in the past 12 months?	I EIVE DITUI		2 Fet	al death 3	Ectopic pregn	ancy	Month Month	Day Year
Sox (leath ce attence for use	SICI	1 Yes 2 No 9 Uni	4 Pregnant at	time of dea	ath 5 Oth	ner (Specify)				
		Part II. Other significant condit		h but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death.  "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	og po		<del> </del>							robably 4 Unknown
tal Records cian: The law requil certificate has been ector, page 2 should	Completed			_				24a. Was a autops perfor	sy prior to	autopsy findings available o completion of cause of
Rec The I	5		<b>.</b>					1 ✔ Yes		
Vital Rec	۱ <u> </u>	25. Was case referred to medica examiner?	Hoopital:	ent 2 🗸	ER/Outpatient		of Death (Check		Residence 6 Oth	ner:
fing Phy After th	<u>ا ۵</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,)	Jry T	28b. Time of I		at Work?		now injury occurred	
trendii death. tor: A	Certification	Natural 5 Pend 2 Accident Invest			Fd 7:15	am 1 Y	es 2 X No	unk		
Divis		3 Suicide 6 X Coul		ijury - At ho House		et, factory, office bu	ilding, etc.	28f. Location (S or Town, S	Street and Number or tate) 2644 Lau	Rural Route Number, City Petta Ave
dospits 4 hours		29a. Certifier	hysician: To the best of m	v knowledo	ne death occur	red at the time dat	e and place, an	Baltime		tated
Division  To the Mospital or Attend within 24 hours after death within 24 hours after death completely filled in by the	Medical	( on our only	miner: On the basis of exa and manner stated.							
1, ESER	ž	29b. Signature and title of certifie				29c. License			29d. Date signed (A	
		Mas .				O.C.N	1.E.		November 24,	2009
		<ol> <li>Name and address of person Ana Rubio MD. Ass</li> </ol>	who completed cause of one sistant <b>Medical Exa</b> n			treet, Baltimo	re, MD 2120	)1		
Sta		31. Date filed (Month, Day, Year)	32. Registra			whol				
Registra	ar	MUTU	JEHUY LEMIN	راس	a. Sulla	Che con				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bell Month 8:31 Susan Cours line November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 436 Ingleside Avenue Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 21.1953 Hours Min Country) Mary Land Months Director 216-68-5862 56 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 21228 USA 436 Ingleside Avenue 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Automobile Service Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Lee Reich Jr. Susan Joan Ussery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 616 Longview Drive Catonsville, Maryland 21228 Susan C. Teague, Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 12/01/09 Lorraine Park Cemetery Gwynn Oak, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor % Name and Address of Facility Home, P.A. MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, any Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MCDI disease or condition resulting in death) 2008-present Medical Due to (or as a consequence of): \_ Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I To the Hospital

> State Registrar

3 🗖

luma

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year).

MUY

only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

00

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

				For State	State of Mar	ryland				and Mental H	ygier	0 0 0 0	07716
				Registrar  1. Decedent's Name (First, Middle, La	net)		Cer	tificate of L	Death	1	Reg.	No. 2009	3//45
		Physicia Media			htwell					2. Date of I Month Novemi		27, 2ď09	3. Time of Death 2:16 A M
(	16	Examir	er	4a. Facility Name (if not institution, giv				4b. City, Town, or		f Death		4c. County of Death	
				Stella Mari  5. Social Security Number   6, 3		In sen los	at birth days	Timor		M Um I o o f		Baltimo	
		Funeral Director		215-40-8592 Usual Residence of Decedent	6ex 1 △ M 2 □ F 68		st birthday) Yrs.	Months Days	Hours	Min. 8. Date of E (Month, I NOV •	Sirth Pay Yea	1940 Mary	lace (State or Foreign Cand
		permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. and any increase 1 show many injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State 10b. County Maryland Baltimo	1		Town or Loc			5(-20-15)		11	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
		or 28	Dir	10e. Street and Number				10f. Zip Code			100	Citizen of What Coun	
		with t	Funeral	1307 Gatefield Ro	ad			21228				USA	.,,
.m.	ထ	within 72 hours after death with the Maryland giene.  giene than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by Fun	11. Marital Status  1X Never Married 2  Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 XNo			as Decedent of H Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - America Black, White, e	
a.	-003	ours aft atural", al Exal	eted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Yes X No				Specify: Whi	
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2009	a	ld be filed Mental Hy arked oth atic event	10	Roy Brightwell						r's Name <i>(First, Middl</i> eresa DeL			
27,		and 2 should Health and Mi iem 27 is mar ither traumati		John Lindner  John Lindner	Type, Print) ., Nephew							or Town, State, Zip C .s, Marylar	
NOVEMBER	Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec		ce	metery, crem	ition (Name of atory or other place ematory I		Date 11/27/09	1	Location - City or To	·
ΔEM	altii	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service Licer	* *								
NO	_	9 9 E 8 9		MICHSY				9 Freder	ick R	oad Baltin	nore	nd, Inc.	1 21228
	P	hysician/ Medical		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. LUNG CAN	ICER		the mode of dyin	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	غميد	Examiner	L		Due to (or as a c	onseque	ence of):						
		nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of liftighry	Due to (or as a c	onseque	ence of):						
p		e execu	al Exa	that initiated events resulting in death) Last	Due to (or as a c	onseque	ence of):						
	760	physic the b	edical		d								
BRIGHTWELL	P.O. Box 687	To the Propriat or Attending Frigschar; the law requires that the cealth certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 2  4  Pregnant at til 9  Unknown	☐ Fetal	death 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of delive Month	ry Day <b>Y</b> ear
GHT	P.O.	ned by detacl	by Ph	Part II. Other significant conditions	contributing to death but	not resu	Iting in the un	derlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute to the	e cause of death?
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Î	_ :	in 24 hour he Funera	Medical	(Check 2 L Medical Exam	rsician: To the best of my niner: On the basis of exan se Practioner: To the best	nination :	and/or investig	gation, in my opinio	n, death occ	curred at the time, date	and pla	ice, and due to the caus	se(s) and manner stated
	7	with con		29b. Signature and title of certifier	SLANT			29c. License	number 979	2	29d. [	Date signed (Month, D	ay, Year)
				30. Name and address of person who				,	m	TID:	100		
		Stat	e	JACKIE JONES, CR 31. Date filed (Month, Day, Year)	32. Registracis			LEY KD.	TIMON	IIUM, MD 2	1093	5	

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Physician/ cal Examiner	1- For State		Certi	ficate of	Death			2	0.00	277
cal Examiner	1. Decedent's Name (First, Middle,L	ast)					. Date of Death		3. Time o	of Death
sal sakalillilel		Raym	iond	But 1			Month November		2056	hrs
	4a. Facility Name (if not institution, g 2500 West Fairmount Av	•	nber)	4	b. City, Town, or Lo Baltimore	ocation of Death		4c. County of	Death	
Funeral			7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	h(MM/DD/YYYY)	9. Birthplace (S	tate or
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	Usual Residence of Decedent	1 24	50				1-0-	1959		11D
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r death with or items 23 must be no Funeral	1 Never Married 2 Marrie	ed Armed For	rces?		es, specify Cuban, I			White,		i, biack,
Fr. or	71	1 Yes	2 X No	1	Yes 2 X No	specify:		Specify:	Bla	ck
"natural" Examine	15. Decedent's Education (Specify	only highest grade	completed) 1		's Usual Occupationst of working life. E			16b. Kind of Bus	iness/Industry	
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led within 72 hour Eggiene. other than "natu the Medical Exar Completed	9th grade 17. Father's Name (First, Middle, La	not)	11/α	1611			irot Midello B		1 1091	20102
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Ment mark c ever	19a. Informant's Name/Relationship			19b. Mailing	Address (Street				, State, Zip Code	2113
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DHIVIN 17 REV 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TTEM# 18 per FH, G898, 12/8/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 03:10 PM 28 09 MASOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Selt-more \ NA 0+ miver Maryland Sit Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F 220-85-9360 Y<sub>rs</sub> **Director** 2009 Nov. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "fatural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Evaminar must be notified at
once. 1 ☐ Yes 2 ☑ No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 96 Fox Haven Court 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) **Toppin** 17. Father's Name (First, Middle, Last) Be William Biles ပ Vera Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. & Mrs. William Biles Parents 96 Fox Haven Court Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 11/30/09 Hampstead, MD 21. Signature of Funeral Service Licensed 22. Name and Address of Facility 11824 Reisterstown Road Sus Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** severe Kespiratory disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner intravent Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) DeNe and Due to (or as a consequence of): The law requires that the death certificate be exe Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🖾 No 1 ☐Yes 2 No 1 Yes the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M,DD0068055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 Baltimore Elias South Greene Abebe, M.D.

Registrar

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Box 68760, P.0. of Vital Records, Division

4+1

24 hours a

within 2

completely

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ELIZABETH HARRIS

State Registrar

Medical

DHMH 17 Rev 1/2001

M.D. 4940 EASTERN AVENUE

and manner stated

32. Registrar's Signature

1au

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

BALTIMORS

29d. Date signed (Month, Day, Year)

NOVEMBER 19,

2009

09-08978 Wayne Brown

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,		For State	Cen	tificate o	f Death			Reg. No	<u>.</u> 20	09 3//4
Physician/ Medical Examine	1	edistrar  Decedent's Name (First, Middle,Last)  Wayne	Brown				1.4	ate of Death onth Day Ovember 19,	Year 2009	3. Time of Death 0928 hrs
)		a. Facility Name (if not institution, give s Northwest Hospital Center			4b. City, Town				4c. County of Dea Baltimore Co	
	-	Social Security Number 6. Sex	7. Age (In yrs. la	st hirthday)	If Under 1		ter 24Hrs. 8.1	Date of Birth (MI	M/DD/YYYY) 9. B	Birthplace (State or
Funeral Director			1 2 F 59	Yr	Months		n Min	uly23,	Fore	eign Country)
	-	Sual Residence of Decedent  0a, State 10b, County	I10c City	Town or Loca	ation					10d. Inside City Limits
Maryland 28a-f show any d at once.		MD Baltimor		altin	nore				(14th -1 Co	1 Yes 2XX No
with the Maryland ns 23a or 28a-f sho be notified at once	1	<sup>0e. Street and Number</sup> 38 Barbician Wa	У		10f. Zip Co 21	<sup>de</sup> 208			Citizen of What Co	ountry?
12 hours after death with the Maryland n'natural", or items 23a or 28a-f she al Examiner must be notified at once	1	1. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U. Armed Forces?  1 X Yes 2 No				rigin? ( Specify in, Puerto Rica		14. Race - Am White, etc.	erican Indian, Black,
fler de		3 Widowed 4 Divorced	1 X Yes 2 No f Yes, Give Year	1	Yes 2 X				Specify: Bla	
"natural Examin	3	15. Decedent's Education (Specify only	highest grade completed)	16a. Decede	ent's Usual Oco	cupation (Giv	e kind of work ( T use retired)	done 16t	o. Kind of Busines	s/Industry
5-0036 led within 72 he Hygiene. other than "na the Medical Ex	najaidillo	Elementary/Secondary (0-12) 12th	College (1-4 or 5+) N/A				Poli	ce S	tate o	f MD
5-0C iled wii Hygier Jother	5	7. Father's Name (First, Middle, Last)						st, Middle, Maid		
21; be fill rked ent,	e e	Timothy Brow		101 11 7				eterso	, City or Town, St	ate Zin Code)
e, MD 2.  I and 2 should Health and M fitem 27 is m; r traumatice	2	9a. Informant's Name/Relationship (Ty Barbara Brown/	spouse	38 E	Barbic	ian W	lay Pi	kesvil	le, MD	21208
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and 1 important: If iten 27 is re		20a. Method of Disposition  1 XXBurial 2 Cremation 3	T	crematory or	osition (Name other place) On For		12/4		oc. Location - City Wings I	Mills, MD.
	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens.	969	22	. Name and Ac	dress of Faci	lity_	, ,		.,0.
Balt permit. Depart Impor	1	Bun V/	Courselie	12	700 Edm	DAGGON	Beve:	rly D.	Croma	tie/f/s Approximate Interval
Physician	3	23a Part I. Enter the disease, or complifailure. List only one cause on each	cations that caused the death	. Do not ente	r the mode of o	lying, such as	cardiac or res	piratory arrest,	shock, or heart	Detween Onser and
/M. di al caminer		Immediate Cause (Final disease a.	Cardiomegaly							Death
			oue to (or as a consequence of CHronic renai		ase					
	<u>.</u>	Sequentially list conditions.	Oue to (or as a consequence of		450					
	티크	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of	A)-				<u> </u>		
executed that and the transit		events resulting in death) Last dd	oue to (or as a consequence of	ar).						
60, cate be exe physician a	Medical	X UNPENDED	AMENDED PI line	a-b,	27, per	ME G	398 12/	29/09 T	T	
760 ficate l		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pres	gnancy	Fetal death		opic pregnancy		23d. Date of deli Month	very Day Year
cath certifications attending	cian	past 12 months?	4 Pregnant at time of d		Other (Specif					
Boy e death the att	S	1 Yes 2 No 9 Unknown	9 Unknown				5 11	23a Did toba	eco uso contribut	e to the cause of death?
P.O.	اھ	Part II. Other significant conditions	contributing to death but not	resulting in th	ie underlying c	ause given in	Part I.			Probably 4 Unknown
ds, equire een sij	Completed							24a. Was an autopsy	24b. Wer	e autopsy findings available to completion of cause of
COF e law r e has b	힐							performe	ed? deat	
Re ii The ifficate or, pag		25. Was case referred to medical			26	.Place of De	ath (Check only		No I	100 1 10
/ital sician sician sis cert sirecto	o Be	examiner?	lospital: 1 Inpatient 2	ER/Outpati	ent 3 DO	A Other	Nursing H	lome 5 Re	esidence 6 C	Other:
of \\ ng Phy After th	⊢ŀ	1 Ves 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time		c. Injury at W	1	d. Describe how	w injury occurred	
icendi leath. tor:	읉	1 X Natural 5 Pending 2 Accident Investigation	on	l		1 Yes 2				r Rural Route Number, City
Divisal or All safter of all Direction by	Certification:	3 Suicide 6 Could not l		home, farm, s	treet, factory,	office building	g, etc.	or Town, Sta		Rural Route Number, Oity
		29a. Certifier	an: To the best of my knowle On the basis of examination	dge, death or and/or invest	ccurred at the t	ime, date and opinion, death	d place, and du	e to the cause( ne time, date an	s) and manner as id place, and due	stated. to the cause(s)
To the vithing To the comp	Medical	29b. Signature and title of certifier	and manner stated.	BAL		License num				(Month, Day, Year)
(A)		G ( ) ( )	le leph	1080		O.C.M.E.			November 20	0, 2009
1 1.x1 pero		30. Name and address of person who of Victor Weedn MD JD A	completed cause of death (Ite ssistant Medical Exam		1 Penn Str	eet, Baltim	nore, MD 2	1201		
Sta	ate	31. Date filed (Month, Day Year)	32. Registrar's Signa			0				
Registi		MOASON	Denous	B. 1	parlo	5.				

OCME

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month <u>Orieal</u> Marie Burcham 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death BAltimore BAIT MORE Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖫 F Months Days Hours Min (Month, Day, Year, 5/30/193) Wisconsin 390–34–4086 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2XXNo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 429 Lorraine Avenue 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No 1 ☐ Yes 2 XNo Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Bartender Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Carpenter Vivian Olson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Ramey (Grandson) 1510 Charmuth Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 20627 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or g Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ANC disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

for use as the burial-trans Division of Vital Records, P.O. Box 68760

Physician/Medical

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Physician/

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Examiner

**Funeral** 

Director

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marked other than "natural", or items 23a or matic event, the Medical Examiner must be n

permit. Page 1 and 2 should be filed within 72 hours after of Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir

Physician

Medical

Examiner

Sur GHのm, OR! Maryland 21215-0036

signed by the a within 24 hours after deat To the Funeral Director:

						1 42 100 2 2	and delinobably recomme
						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to med examiner?  1  Yes 2 No	1	ospital:	ER/Outpatient	з 🗆	eck only one)  Home 5  Residence 6 Other (Specify)		
	estigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
	ould not be etermined	28e. Place of Injury - At he building, etc. (Specify		t, fact	ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature d title of certifier

D0063

ess of person who completed cause of death (Item 23a) (Type, Print)

BELVE DEREA 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Registra

ORIGINAL

Physician /Medical **Examiner** 

death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760

0	Louis		Hulshu	It   Julia	Ann		Menke			
	19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Mailing Addr	ess (Street and Number or	Rural Route Number, Cit	y or Town, State, Z	Zip Code)			
	Timothy R. McElfre	sh/ Son	18466 T	hree Notch R	oad, Lexing	ington Park, MD 20653				
	20a. Method of Disposition		Place of Disposition (I	ce of Disposition (Name of Date 20c. Location - City or Town, State netery, crematory or other place)						
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 🛣 Donation 5 ☐ Other (Specify)	emoval from State	tany Gifts R	, ,	/24/2009 Ha	anover, M	Maryland			
Ì	21. Signature of meral Service License		22. Name	and Address of Facility	Anatomy Gift	ts Regist	ry			
-	BUDE		/522	Connelley D	r., Ste.P, I	Hanover,	MD 21076			
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea	th. Do not enter the n	node o wing, such as card	liac or respiratory arrest,		Approximate Interval Between Onset and Door			
Ì	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	cinom	aloses			Month Month			
- 1		Due to (or as a consec	a Va	MAAD			140			
5	Sequentially list conditions, if any, leading to in modical cause. Enter Underlying Cause (Disease or injury	Due to (or as a consic	en e of):	Me			-17)			
1	cause. Enter Underlying Cause (Disease or injury that initiated events	(					V			
Cyalliner	resulting in death) Last	Due to (or as a consec	juence of):		· · ·					
	d									
פֿל										
A /	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome pf pregn	ancy			23d. Date of deli	iverv			
2	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		pregnancy (specify)		Month	Day Year			
completed by Physician/Medical	9 □ Unknown	9□Unknown								
-	Part II. Other significant conditions conf	tributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?			
2	COPI	D ,			1 ☐ Yes	2 No 3 ₽ Pr	obably 4 □Unknown			
	Annias	DE MAL	Seon		24a. Was an	24h. Were au	topsy findings available			
	7000	9/3		· · · · · · · · · · · · · · · · · · ·	<ul> <li>autopsy performed?</li> </ul>	prior to death?	completion of cause of			
	25. Was case referred to medical	nua		26 Place of F	1 Yes 2	Vo 1 ☐ Yes	2 No			
1	average and	ospital: 1 ☐ inpatient 2 ☐	ER/Outpatient 3	Other	eath (Check only one)	о Пон- · / О ·	-4.3			
2	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	Home 5 Residence		ony)			
	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No						
Columbation	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	l ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,			
E C	29a. Certifier 12 Certifying Physi	lalan. To the best of line	vuladas dastis s	and and the a time and a time a time and a time a time and a time a time and a time a time and a time a time and a time a time and a time a time and a time a time and a time a						
3	(Check only 2 Medical Examin	ician: To the best of my known or the basis of examination	ation and/or investigat	eu at tine time, date and pla ion, in my opinion, death of	ccurred at the time, date a	(s) and manner as	stated.			

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title

James P

31. Date filed (Month, Day, Year)

of certifier

Jarboe

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

24035 Three Notch Road, Hollywood, MD 20636

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien2009Certificate of Death 3. Time of Death P 1. Decedent's Name (First, Middle, Last) 2. Date of Death /Month **Physician** lovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMOFR ar It Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1□M 2**/**F Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-f show Ith and Mental Hygiene. 27 is marked other then "naturel", or iteme 23e or 28a-f ehov treumatic event, the Mudical Examinar mant by molfied at 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 20 No Specify. Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil tment of Health and Mental H tant: If Itam 27 is marked oth Jury or other treumatic even 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State State, Zip Code) 19a. Informant's Name/Relationship (Type, Prin. 20b. Place of Disposition (Name of cametery, crematory or other p Date 20a. Method of Disposition 20c. Location 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice ee 22. Name and Address of Facility Funera L. Russ I W. North Avei 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (orlas a consequence of): Physician /Medical Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Dementie Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 3 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Madence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Delea

leted cause of death (Item 23a) (Type, Print) 70 5

29c. License numbe

UNTHICUM MY

29d. Date signed (Month, Day, Year)

12009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 /Medical Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min. 1 M 20 F Days Hours 7 Director 16 inia permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If lem 27 is marked other than "natural" or home any injury or other traums in any injury or other traums in the maryland any injury or other traums in the maryland injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traums injury or other traum 10a. State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 □ No 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Blace 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bets nee ပ ackson 19a. Informant's Je/Relationship (Type. Print) (Son) 19b. Mailing Address (Street and Number or Rur I Route Number, City or Town, State, Zip Code) ourtney Rd awrene MO 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 30/200 4 □ Donation 5 □ Other (Specify) On Poseph 21. Signature J Fun ral Service Licens and Address of Facility uneral Ave North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and physician and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perfor death? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □ Yes 2  $\square$  No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) AQ 8 FLEW 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Juanita Barnes 2009 3:45a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4312 Reisterstown Road 8. Date of Birth (Month, Day, 1) Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months Year) 1 □ M 2**X**□ F **Director** 77 243-40-2370 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant or other traumatic event, the Medical Examination. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Baltimore 1X Yes 2 ☐ No MD NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 4312 Reisterstown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seminary <u>llth grade</u> Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parthenia Patterson Clarence Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4312 Reisterstown Road, Baltimore, Md21215 David Barnes Sr.-Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 11/28/09 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician, CRINE DAIR VC41 Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury work' 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar

State

30. Name and address of person wh

npleted cause of death (Item 23a) (Type, Print) ソク タリスシン・Bc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 23, **Physician** BENJAMIN 2009 1:00 PM B00K0FF /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ENVOY OF PIKESVILLE BALTIMORE BALTIMORE If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday **Funeral** Months Days 1 X M 2 □ F Hours Min. MD 215-14-0136 05-27-1918 91 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No Director MD BALTIMORE BALTIMORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 346 HUMMINGBIRD WAY 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 Married 1 ∐Yes 2 🕱 No Specify. If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GROCERY STORE OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ABRAHAM BOOKOFF** LEAH WACHS ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEATRICE BOOKOFF/WIFE 346 HUMMINGBIRD WAY, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP CEM: 11-24-2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROTHERS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ns\_t and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 T Yes Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No URC 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 00 Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 <sup>™</sup> Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

requires that the death certificate σ. Division of Vital Records, The law To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
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27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Examinating the profitted at

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The M

within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated.

32. Registrar

30. Name and address of person who completed cause of death (Item-23a) (Type, Print)

10

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last Day SV **Physician** November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 506 Milton Ave If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Sex 1 ☑ M 2 ☐ F Days Hours 218.22.2853 80 Director Dec 11, 1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any liury or other traumatic exercises." 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2√No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA by Funeral 21061 506 Milton Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ∑Xes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced Ye ar or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paint Industry Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Viola Lawrence Thomas J. Bruns, Sr. ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Milton Ave, Glen Burnie, MD, 21061 Wife Nancy Bruns 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Nov 24, 2009 Crownsville, MD rownsvill¢ Veterans Cem 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licen Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 M01 48 Part 1. 3 reter the dileast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Yet only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 ☑No 1 □Yes 2 No 1 ☐ Yes neral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To HOUPE 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and Itl 29c. License number death (Item 23a) (Type, Print) Name and address of person who completed caus W

Registrar DHMH 17 Rev 1/2001 Date filed (Month, Day,

32. Registrar's Signature

State

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 24, 2009 **Physician** 8:00A.M Edward G. Bullinger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Overlea 227 Marion Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7 - 13 - 1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 □ F Maryland 212-28-3759 81 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10h County 10c. City, Town or Location 10a. State items 23a or 28a-f show her must be notified at 1 ☐ Yes 2 ☐ No Overlea Md. Baltimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236-4209 USA 227 Marion Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 XI Yes 2 □ No If Yes, Give Year or Dates:1948 - 52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 5 event, the Midical Exami 1 ☐ Yes 2X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Casper G. Sippel Elementary/Secondary (0-12) College (1-4or 5+) than Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie J. Strasburg is marked Charles E. Bullinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) onto 2 oportant: If item 27 is r v Injury or other Marion Avenue Nottingham, MD 21236 Marv Bullinger - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11 - 30 - 091 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Michael's Ukranian Dundalk, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Robert 1201 Dundalk Avenue Baltimore, Md 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dax /Medical Doe to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen-Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): burial Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🖾 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be SHICK 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicid 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an title of certifier November 25, 2009 D 54426 30. Name and address of person who completed care of death (New 23a) (Type, Print)
Dr. Michael D. Zang M.D. 7602 Belair Road, Baltimore, Maryland 21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

09-09038 Harry Cockran Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larry Cockran		State of Maryland / L For State egistrar	Certificate of			Reg. No. 20	09 3775
Physician/ Medical Examine		Decedent's Name (First, Middle,Last) arry Warren Cockran			2. Date of D Month Novemb	Day Year Der 21, 2009	3. Time of Death 1540 hrs
		a. Facility Name (if not institution, give street and number)  Harbor Hospital	1	4b. City, Town, or Local Baltimore		4c. County of Deat	th
Funeral Director		. Social Security Number 6. Sex 7. Age (III 2 1 7 - 7 2 - 0 6 6 7 1 X M 2 F 5	n yrs. last birthday) 2 yrs	Months Days H	Under 24Hrs. 8. Date of lours Min. Oct.	Birth (MM/DD/YYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYY	
ow any	1	Isual Residence of Decedent  Oa. State 10b. County 10a  Maryland Dorchester	c. City, Town or Locat Cambridge				10d. Inside City Limits  1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	1	Oe. Street and Number 764 Foxtail Drive		10f. Zip Code 21613		10g. Citizen of What Co United Stat	
r death with or items 23	1	1. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X 3 Widowed 4 N Divorced If Yes, Give Year	No If Y	es, specify Cuban, Mex	c Origin? (Specify Yes or kican, Puerto Rican, etc.)	White, etc.	rican Indian, Black,
72 hours afte n "natural", al Examine eted by	? -	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Deceder during m	nt's Usual Occupation (in ost of working life. DO	Give kind of work done	16b. Kind of Business	
21215-0036 uld be filed within 72 hour Mentel Hygiene. marked other than "natue event, the Medical Exan		7. Father's Name (First, Middle, Last) Joseph Cockran	Pri		other's Name (First, Midd		
MD 212 d 2 should be lth and Menta n 27 is marka aumatic even	2 1	9a. Informant's Name/Relationship (Type, Print ) Ashley Cockran/ Daughter	149	g Address (Street and West Meadow	Number or Rural Route  Noad Brook	Number, City or Town, Sta Llyn, Marylai	nd 21225
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	crematory or of Metro Cre	ematory  Name and Address of F	Nov. 2/, 2009	Society of Mary	e, Maryland_ yland, Inc.
M	1	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not enter	the mode of dying, such	n as cardiac or respiratory	altimore, Mar varrest, shock, or heart	ryland 21228 Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Complication to or as a consequentially list conditions,	ions of Ml uence of):	xed drug 1	ntoxication		
ted Innsit	Lyanine	of any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (c. Due to (or as a consequence of the cause					
60, ate be execu hysician and e burial - tra	2010	X UNPENDED AMENDED 23a,		perME, g898	3 12/17/09 T	T	
Division of Vital Records, P.O. Box 68760, sopplar or attending Physician: The law requires that the death certificate be executed hours after death. After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transit Certification: To Re Completed by Physician/Medical Ex	2	F FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant at tin 9 Unknown	2 F	etal death 3 E	Ectopic pregnancy	23d. Date of deliv Month	ery Day Year
ires that the de signed by the bedetached for the by the bedetached for the by	2	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause giver	23e. D	oid tobacco use contribute Yes 2 No 3 P	
Division of Vital Records, P.O. To the Efostlat or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach indicated.	Completed				a	utopsy prior t performed? death	autopsy findings available to completion of cause of ? Yes 2 No
ital Fisician:	e l	25. Was case referred to medical examiner?  Hospital: 1 Van 1 Inpatient	2 ER/Outpatier	1Oth	Death (Check only one) er: Nursing Home 5	Residence 6 Ot	her:
on of Vi ending Physicath.  The After this be funeral dir		27. Manner of Death  Natural 5 Pending Fd 11/17	28b. Time of	Injury 28c, Injury at	t Work? 28d. Desc	ribe how injury occurred	
Division o To the Bostlal or Attending within 24 hours after death To the Funeral Director: Afte completely filled in by the fune	Sertifica	3 Suicide 6 X Could not be determined (Specify) I	ry-Athome, farm, str Hospital	eet, factory, office build	Harbo	wn, State) or Hospital,	Rural Route Number, City Baltimore MI)
To the Hospital within 24 hours To the Funeral completely filled	gical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	knowledge, death occi nation and/or investig	urred at the time, date a ation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner as s date and place, and due to	stated. the cause(s)
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ĭĕ	29b. Signature and title of certifier		29c. License nu O.C.M.E		29d. Date signed (	
		30. Name and ad less of person who completed cause of dea Pamela E. Southall, MD Assistant Medic			Baltimore, MD 2120		
Stat Registra		31. Date filed (Month, Ray Year) 32. Registrar's		ulal			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:55 P M 29, 2009 Emma Edwards Carski November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6500 Woodbridge Circle Baltimore Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Director 93 215-09-8086 24, 1916 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ral", or items 23a or 28a-f shov Director MD Baltimore Catonsville 1 □Yes 21 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6500 Woodbridge Circle 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ZMNo If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ۇ ك 3 A Widowed 4 ☐ Divorced "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) Complaint Adjuster Montgomery Ward ant of Health and Mental Hitt If item 27 Is marked oth y or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William David Devese 2 Lily May Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9047 Furrow Avenue; Ellicott City, MD 21042 Rebecca Weaver Daughter Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park | 12/4/2009 | E1kridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. ignature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive **Physician** muc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2-No 1 ☐ Yes 2 ☑ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence this 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F safter death. I Director: After d in by the funera After Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral D the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signate e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 951 ca and address of person who completed cause of death (Item 23a) (Type, Print) e JU 25 IMCC1 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month 1853-M hapman - Hall 22 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical
5. Social Security Number 6. Sex 7. Age (1) Baltimore. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ **x**F Days Hours Min. 219-40-9052 1945 Maryland 14, Director Aug. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 ☐ No Gwynn Oak Directo Baltimore Maryland 10f. Zip Code 21207 10e. Street and Number 10g. Citizen of What Country? 6526 Woodgreen Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Interest if them 27 is marked other than "natural", or ite mry or other traumatic event, II Mental Textrin III yor other traumatic event, III Mental Textrin III yet other traumatic event, III Mental Textrin III was the statement of the second of the s Specify: Black 1 Never Married Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Maryland College (1-4or 5+) Elementary/Secondary (0-12) Statistician Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Chapman Unknown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6526 Woodgreen Circle Gwynn Oak, Maryland 19a. Informant's Name/Relationship (Type. Print) James R. Hall/Husband permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr. 21207 altimore, 11/28/09 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus, Maryland Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 27 days **Physician** & their complications a. Fall with multiple injunes disease or condition resulting in death) CARRESTAN BY MINE OF IN SECOND TO THE PERSON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Month Year 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cources Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death.

I Director: Af
d in by the fur 1 Tyes 127/2009 -2200 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Home

6526 Word Green Circle Gwynn Oale, Mo

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 120 7

And manner stated

and manner stated within 24 hours a To the Funeral D 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/22/2009 100128 Resident Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Borla 22 S. Green Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Alma Charlotte Cluse рм November 28, 2009 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Montgomery Hospice Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/19/1920 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 061-14-1210 89 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Prince George's College Park Director 1 X Yes 2 □ No 28a-f 7 is marked other than "natural", or items 23a or 28a-f traumatic event, the the start aims must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 USA 4804 Drexel Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after Hygiene. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Buckley Helen Boohr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Gregg Road, Brookeville, MD 20833 Shelley J. Bontz /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 11/30/2009 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Funeral Service License Dorota Marshall. Maishall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Debility /Medical Due to (or as a consequence of): Examiner Small Bowel Obstruction Sequentially list conditions, Examiner Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Strangulated Hernia sician and burial-trans Due to (or as a consequence of) attending physician for use as the buriar Box 68760 Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ANo Month Day Ye ar Pregnant at time of death 5 ☐ Other (specify) P.O. | the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Atrial Fibrillation, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 : certificate 1 □Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  ${}_{4}\square$  Nursing Home  ${}_{5}\square$  Residence  ${}_{6}\Delta$ Other (Specify) Hospice2**K** No 1 ☐ Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation ithin 24 hours area of the Funeral Director: After a smaller of the Funeral Director of the funeral of the fune 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koncet chou, 863 740 11/29/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koueitchou, M.D. 6001 Muncaster Mill Rd, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 3 II ZUUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dale Fedele A. Crispino, Sr. Physician/ <sup>Day</sup> 2009 November 23 6:20 A. Medical Facility Name (if not institution, give street and number) Gilchrist Hospice Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson 5. Social Security Number 213–26–7078 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours . 1<u>930</u> 1 X M 2 🗆 F ADril 10. Director West Virginia Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5701 Fair Oaks Avenue 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) TOOL Repairman 16b. Kind of Business Industry (Specify only highest grade completed) Elementary 60conday (0-12) College (1-4 or 5+) General Motors Be 17. Father's Name (First, Middle, Last) Nichola Crispino 18. Mother's Name (First, Middle, Maiden Surname)
Antoinette Maiocco ဂ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode, 5701 Fair Oaks Avenue Baltimore Maryland 21214 Minerva Crispino/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 11/28/09 Baltimore Maryland . Signature of Funeral Service Licenses Panagadiddenser Faciling 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition intacin Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pryumoni 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 VeNo 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 🕅 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury Natural work?
1 Yes 5 Pending within 24 hours after death.

To the Funeral Director. Af completed filled in by the fu 2 🗌 No Investigation
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the lewithin 2, 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 TOWIN GBMC

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10d Per FH 6898 12/07/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2009 Catherine T. Cording 8:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15810 Wayne Avenue Prince Georges Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 😾 90 Months Days Hours Min. 114-10-6717 0872471919 New York **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant, If them 27 is marked out than "natural", or items 23a or 28a-f show ant, If item 27 is marked out than "natural", or items 2aa or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Tes 2XXNo MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15810 Wayne Avenue 20707 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes. Give Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Dunne Margaret Buckley 19a. Informant's Name/Relationship (Type, Print)
Margaret Walsh/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15810 Wayne Avenue, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation Services 11/27/2009 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important; If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland 21. Signature of Funeral Sepace Licensee 22. Name and Address of Facility Argent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tas toetic Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Day Year 2 No the detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been siy completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗆 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7358 VANDUSIA RD. LAUZEL 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signat State 30 2009 Registrar

enniter Suzanne		1-For State Registrar Certificate of Death Reg. No. 2009 3776
Physicia ledical Exami		1. Decedent's Name (First, Middle, Last)  Jennifer Suzanne Cree  2. Date of Death  Month Day November 22, 2009  3. Time of Death 1306 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 11251 Crystal Run #B 4c. County of Death Howard
Funeral Director		5. Social Security Number 224-31-0623 6. Sex 1 Age (In yrs. last birthday) 31 Yrs. 6. Sex 1 Age (In yrs. last birthday) 31 Yrs. 6. Sex 1 Age (In yrs. last birthday) 4. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Virginia
nd show any ice.	5	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   10b. County   10c. City Town or Location   10d. Inside City Limits   1 Yes 2 X No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  11251 Crystal Run Unit B 21044 USA
r death or ite	Fune	11. Marital Status 1
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	eted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	Completed	4 Police Officer Howard Co. Police Dept  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
1D 21215-00( 2 should be filed with: and Mental Hygiene 27 is marked other th matic event, the Med	Be	John Christopher Peters Cynthia Jame Cree
MD 2. 2 should: 3. h and M 2.7 is m: umatic e	ြ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Cynthia J. Cree (Mother)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1652 Castlefield Road Virginia Beach, VA 23456
글 등 등 등	į	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date  20c. Location - City or Town, State crematory or other place)
Baltimore, permit. Pages I a Department of He Important: If ite		Atlantic Crematory 11/28/09 Glen Burnie, MD  22. Name and Address of Facility
Ba pern Dep Imp	1	Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd Elkridge, MD 21075  23a. Pan. Enter the disease, or complications year caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near Approximate Interval
Physician Medical xaminer	1	Immediate Cause (Final disease a. Cardiac arrythmia Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Cause Sequentially list conditions, if any, leading to immediate cause in the cause of the conditions of the cause of
nd ransit		(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.
O, be exertised a sician a	edica	Xunpended 23a,PII,27,perME, g899 1/8/10 TT
tox 68760, eath certificate be executed a attending physician and for use as the burial - transit		IF FEMALE:     23c. If yes, outcome of pregnancy     23d. Date of delivery       23b. Was decedent pregnant in the past 12 months?     1
P.O. Bs that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  As thma  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown
cords, Fe law requires e has been sign	Completed by	24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The his certificate director, page	Be Co	25. Was case referred to medical 26.Place of Death (Check only one)
ing Physical After this	ပ	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other: Scene  27. Manner of Death  1XX Natural 5 Pending  Pending  Other: 4 Nursing Home 5 Residence 6 Other: Scene  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  1 Yes 2 No
Divisior Hospital or Attene 24 hours after death Funeral Director: tely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hosp within 24 ho To the Fune	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F. W F. 8	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  November 23, 2009
d		30 Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Si Regis	tate trar	
DHMH 17 Rev 1/2		ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 10:50p Betty Lou Cobbs Covington 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Future Care Nursing Home  ${ t Baltimore}$ . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗆 F Months Hours Min. (Month, Day, Year) Country) 76 Director 239-66-7430 26 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Baltimore MD Randallstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 U.S.A. 8507 Fieldway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sallie Ratley Willie Cobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8507 Fieldway Drive, Randallstown, Md 21133 Esther White-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Memorial Park 11/30/09 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ CD-0/12 disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit N 0 Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day signed by the a d be detached f Yes 2 No. 9 Unknown g 🔲 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Her Entension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? DIABLIES 24a. Was an has autopsy CARLONO MYOPATHY performed 1 ☐ Yes 2 ☑No certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **M** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, it my operation and place and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 200 3

Registrar

State

30. Name and address of person who complet

ADETEMSI

31. Date filed (Month, Day, Year)

5311

OLD

COURT

RD

RANDALLSTOWN MD 2113R

cause of death (Item 23a) (Type, Print)

YA

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Gretschen D. Camp November 17, 2009 9:05 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Securify Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 51 1 □ M 2 🗓 F 216-72-2476 Director October 30, 1958 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shor the Medical Examiner rust be notified at 1X Yes 2 □ No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 Tripoley Court 20878 United States by Funeral mit. Pages 1 and 2 should be filed within 72 hours after death aartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23 Injury or other traumatic event, the Medical Examinating 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Scientist Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edward Camp, III Virginia O'Donnell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important; If item 27 is
any Injury or other trau Sophia Parkes/Friend 1368 Sheridan St. N.W., Washington, D.C. 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ XCremation 3 ☐ Removal from State Montgomery Crematorium Nov. 22, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

HOUN 11. MG 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. Chail M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer 5 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Examine Due to (or as a consequence of) physician and the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 5 ☐ Other (specify) ed by the a detached fr Ö 1 ☐ Yes 2 X No 9 Unknown σ. s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate of Vital 2 X No 1 ☐ Yes 2 🗆 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 🕱 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation ieral Director; A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

29b. Signature and title of certifier

Nelson Kalil, M.D. 5454 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

454 Wisconsin Avenue #1300
32. Fegistrar's Signature

D51616

29d. Date signed (Month, Day, Year)

November 19, 2009

Chevy Chase, Maryland 20815

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 22, 2009 **Physician** 10:20 P M Edgar Robert Caster /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth November 7,1932 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🖾 M 2 🗆 F Months Days Hours Indiana 314-28-0253 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It & Mudical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Bethesda North 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 United States 5550 Tuckerman Lane #256 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 쩘Yes 2 및 No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Director of Indian Health Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Nadin Bray Oscar Caster ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12100 Serenity Place, Nokesville, Virginia 20181 Gabrielle Caster Mella/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 28, 2009 4 Donation 5 Dother (Specify) Cemetery 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01305 Rockville; Inc. 300 West Maryland 20850 Mon Rockville; Mary Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Cardiomyopathy Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sone-quenes of): Examiner Renal Failure signed by the attending physician and I be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical Diverticulitis IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cords, ğ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 反 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di Examinar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title November 22, 2009 D53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3200 Tower Oaks Blvd., Rockville, Maryland 20852 Ajay Reddy, M.D. 31. Date filed (Month, Qay, Yea 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

/alter James C	•	enter State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Maryland / Department of Lagrangian State of Lagran	Health and Mental Hyg		2000 2777
Physici		Registrar  1. Decedent's Name (First, Middle,Last)	2	Reg. No. 1. Date of Death	3. Time of Death
Pnysici Nedical Exami	2111/	Walter James Carpent	er	Month Da November 23	ay 3, 2009 0058 hrs
		4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death		4c. County of Death
		o o i i i o p i i i o o p i i a i	Baltimore		N/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth (N	MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		216-02-3287 1XM 2 F 27 Yrs.	Monard Days Frodris Willi.	11-19-	1982 Maryland
ıy		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1 ow any					1 Yes 2 X No
72 hours after death with the Maryland n "matural", or items 23a or 28a-f show al Examiner must be notified at once.	cto	Maryland Baltimore Ellicott  10e. Street and Number	City 10f. Zip Code	10g.	Citizen of What Country?
ne Mai or 28:	Director		21043		
vith th s 23a e noti		713 Pleasant Hill Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Indian, Black,
eath v item	Funeral	Armed Forces?	, specify Cuban, Mexican, Puerto R	Rican, etc.)	White, etc.
ffer d I", or			es 2 X No specify:		Specify: White
ours a atura xamir	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kind of working life. DO NOT use retire		6b. Kind of Business/Industry
6 1,72 h an "n cal E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	tor working inc. Bo the case round		
15-0036 filed within 72 hours after Hygiene. 2d other than "natural", o	Completed	12 Art	18.Mother's Name (	First Middle Mai	Architectural Firm
15-1 filed al Hyg ed oth		17. Father's Name (First, Middle, Last)	7.7		1711
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. Iant: If item 27 is marked other than or other traumatic event, the Medica	To Be	Richard B. Carpenter  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing A	Address (Street and Number or Ri	inifred ural Route Numbe	Wilson er, City or Town, State, Zip Code 21043
MD 7 d 2 shou lth and I n 27 is r		Winifred W. Carpenter Mother 713 P1	easant Hill Rose	1 Ellico	ott City. Marvland
ore, ME ss 1 and 2 s of Health a If item 27		20a. Method of Disposition 20b. Place of Disposition	on (Name of cemetery,	Date 2	ott City, Maryland 20c, Location - City or Town, State
nor ages and of a		1 X Burial 2 Cremation 3 Removal from State Saters Bar	ptist 11 2	5 2000	Baltimore Maryland
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify Church Cer 21. Sin ture of Fine J Servic Licensee 22. Na	me and Address of Facility Pug	2-2009 I	Functal Home Inc
Ba pern Dep Imp	0.53	tout tran 10.	50 York Road T	owson, M	Baltimore Maryland Funeral Home, Inc. Maryland 21204
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac or	respiratory arrest	, shock, or heart Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Sphyxia by hanging			Death
kaminer		or condition resulting in death)  Due to (or as a consequence of):			
	L	Sequentially list conditions,   b.			
	ine	cause. Enter Underlying Cause			
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
be executed ician and arrial - transit	ョ	d			
be experience of the control of the	dical	UNPENDED X AMENDED Item#12perFH,G8	98,12/7/09,WS		
766 ficate g phys	Ĭ,	IF FEMALE: 23c. If yes, outcome of pregnancy	Il death 3 Ectopic pregnar	ncv	23d. Date of delivery  Month Day Year
Ox 68760, eath certificate be attending physic for use as the bur	sician/Me	past 12 months?  4 Pregnant at time of death 5 Other	er (Specify)	,	
Box 68760 e death certificate b the attending physic cd for use as the bu	ıysi	1 Yes 2 No 9 Unknown g Unknown			
ch by	y Phy	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to the cause of death?
s, P.C irres that signed d be deta	d by				2 No 3 Probably 4 Unknown
ords, w requires been should	ete			24a. Was an autopsy	prior to completion of cause of
eco he law ite has	Completed			perform 1 Yes 2	
Division of Vital Records, tal or Attending Physician: The law require also deter death an Director. After this certificate has been sited in by the funeral director, page 2 should be	Be C	25. Was case referred to medical	26.Place of Death (Check of	only one)	
Vita ysicia this ce	To B	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 V ER/Outpatient	3 DOA Other Nursin	g Home 5 Re	esidence 6 Other:
ing Ph After t		27. Manner of Death 1 Natural 5 Pending FOUND: 28a. Date of Injury FOUND: FOUND:		28d. Describe ho Subject hange	
ion tendii eath for: /	ati	1 Natural 5 Pending FOUND: Nov 22, 2009 2349 hrs	1_ Yes 2 ✔ No		
ivision or Attendather death Director:	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	, factory, office building, etc.		reet and Number or Rural Route Number, City ate)
Divis pital or At ours after d ceral Direct	l e	4 Homicide determined (Specify) Multi-Family Apt.			ate) Avenue Apt. B401, Baltimore, MD
Division To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only	ed at the time, date and place, and	due to the cause(	(s) and manner as stated.
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.			
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	ļ	Calmin	O.C.M.E.		November 23, 2009
		30. Name and address of person who completed cause of death (Item 23a)	Ohne A Deline and AAD 04	201	
			Street, Baltimore, MD 21	ZUT	
	tate	AITH/ 2 0 2006			
Regi		Thomas of March			A His
DHMH 17 Rev 1/	2001	ORIGINAL	_		

		-	For State Registrar	State of Ma	aryland .		irtment of H <i>tificate of D</i>		and M	_	giene Reg. No.	2009	37771
	Dhysisis	n/	Decedent's Name (First, Middle	, Last)						2. Date of De		Year	3. Time of Death
	Physicia Medic	al		bert M.	Cc	nnor				Novembe	er 23	, 2009	12:30 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, Gilchrist	give street and number)			4b. City, Town, or Towson				Ba	County of Deat	e
	Funeral Director		5. Social Security Number 703-07-9597	6. Sex 1 ★ M 2 □ F	e (In yrs. last i 86	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 4/1/14/15		9. Birl	thplace (State or Foreign untry Mary land
	and show dat	اة	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits
	e Mary r 28a-f notifie	Director	Balti 10e. Street and Number	more	Balt	more	10f. Zip Code			1	10a Citi-	zen of What Co	1 Yes 2 No
	with the s 23a o	Funeral	6514 Banbury R	oad			21239	_				JSA	
920	e filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show ed out, the Medical Examiner must be notified at	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4XXDivorced	IAMA Cive		If	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 No	spanic Orig n, Mexican Specify:	, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	thin 72 hour sne. than "natui he Medical	Completed		nt's Education st grade completed)  College (1-4 or 5		(Give k	ent's Usual Occupa ind of work done d O NOT use retired)		t of workir	ng	1	ansport	
land 2	buld be filed within d Mental Hygiene. marked other the matic event, the I	0 1	17, Father's Name (First, Middle, L John S. Connor					18. Mothe	er's Name	(First, Middle,	Maiden S Cabe	Surname)	
Mary	shou h and 7 is m rraum		19a. Informant's Name/Relations				g Address (Street a						
Baltimore,	and Heal tem		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (\$	3 ☐ Removal from State	20b. Plac	e of Dispo	sition (Name of natory or other plac	!	D	7/2009	20c. Lo	cation - City or	Town, State
Balti	permit. Page 1 Department of Important: If i any injury or once.		21. Signature Funeral Service L		lin	- R	Name and Addres	s of Facilit	y Toy	vs∩nme,	laryla	and 212 1050	94 York Road
	cate be executed  Medical Examiner  the burial-transit	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Subdy Due to (or as b. Lus to (or as c. Due to (or as	a consequen	ce of): ~+ ev	atoma	iso					Interval Between Onset and Death
. Box 68760	th certific ittending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Fetal d	eath 3 🗆	Ectopic pregnand Other (specify)	ey .				23d. Date of de Month	olivery Day Year
s, P.O.	ires that the dea signed by the a Id be detached I		Part II. Other significant condition	ons contributing to death t	out not resulti	ng in the u	nderlying cause giv	en in Part	I.				the cause of death?  Probably 4 Unknown
Division of Vital Records,	Physician: The law requirer r this certificate has been si rral director, page 2 should b	Completed by			_					24a. Was auto perf 1 \( \subseteq Yes	s an opsy formed? 2 No	prior to	utopsy findings available completion of cause of
tal	cian; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Dea					
of V	y Phys er this eral dir	e: 10	1 Yes 2 □ No 27. Manner of Death	28a. Date of inju			nt 3 🗆 DOA	4 ∐ Ni yat		me 5 ∐ Res 28d. Describe			ify) Hospice
lon	eath. or: Afte	ficat	1 Natural 5 Pendi 2 Accident Investi 3 Suicide 6 Could	gation November 17	2009 11	Bb. Time of injury		Yes 2		Fa	11		
<b>Divis</b>	al or Attendi s after death. I Director: A id in by the fu	Cert	4 ☐ Homicide determ	28e. Place of Inj	c. (Specify)	_	eet, factory, office	t			wn, State)	101.1	hewik, ND 21093
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical Certificate:	(Check 2 Medical)	Physician: To the best of	my knowled	ge, leath o	tigation, in my opinio	on, death o	place, an	d due to the c	ause(s) and and place,	d manner as st and due to the	cause(s) and manner stated.
FI	To the within To the comp	2	29b. Signature and title of certifie	LMD D.	aput.	1	29c, Licenso		7		29d. Dat	nber 2	th, Day, Year)
_			30. Name and address of person	who completed cause of	rimnic	3a) (Type, F	CT. Luthe	50:1	le.t	SAM	109	3	
	Sta Registr		31. Date filed (Month, Day, Year)	9 Seguera	ar's Signatur		a	-	-1				

			for State Registrar	State of M	laryland / D	epartmen Certificate			and M	ental H		009	3	7772
			Decedent's Name (First, Middle)	e, Last)			0 01 1			2. Date of D	Reg. No			e of Death
	Physici /Medi		Dorothy	LaRue	Dol	ner				Month ()	23 2	Year		2 4 A M
· Par	Examir		4a. Facility Name (If not institution				Town, or	Location o	of Death			nty of Deat		
-			FRANKLIN 3QL	acre Hosi	Pital Cent	Er Ro	05 ec	lale			Ba	UTIN	10re	
	Funeral		5. Social Security Number		ge (In yrs. last birth	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D	irth Day, Year)	9. Birtl	hplace (Sta	ate or Foreign
	Director		Usual Residence of Decedent	1 L W 2 4 4 1	74 Y	rs.	,			Nov 21	, 1935		nnsy1	vania
	land ow		10a. State 10b. County		10c. City, Town	or Location							10d. Inside	e City Limits
	Mary L-f sh	ţō	Maryland Balti	moro	D.	altimore							1 🗆 Y	Yes 2∭ No
	h the	Director	10e. Street and Number	more	Do	10f. Zip					10g. Citizen o	f What Co	untry?	
	th wit		1301 Gunpowder	Crossing I	ane		212	220			USA	A		
•	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Modical Examiner must be redified at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Deced	dent of Hi	ispanic Orig	gin? (Spe	cify Yes or N	o- 14. Ra	ace - Ame	rican Indian	١,
36	or if	by Fi	1 Never Married 2 Marri	ied 1 □Yes 2 🛱 If Yes, Give	No	1 □ Yes 2		Specify:	,	,,	Spec		, 610.	
9	hour tural'	q pe	3 ☐ Widowed 4 🕅 Divorced	Year or Dates:		Nagadanila Harra		-41				W	hite	
15	in 72 n "na n ole	Completed	15. Decedent (Specify only highes	st grade completed)		Decedent's Usua Give kind of wor life. DO NOT us	rk done d se retired	ation furing most ')	of workin	g	16b. Kind of	Business/i	industry	
212	yiene giene r tha	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Data Pr					Proper	rtv M	lanage	ment
	_ 0 0	Be C	17. Father's Name (First, Middle,	Last)					r's Name	(First, Middle	e, Maiden Surna			
Maryland 21215-0036	should be filled vand Mental Hygies marked other tumatic event, to	To E	George	Pro	ud			Jea	an	1	Maude		Punc	hois
lar	2 sho and is ma		19a. Informant's Name/Relationsh	nip (Type. Print)	19b. N	Mailing Address	(Street a	and Numbe	er or Rura	Route Num	ber, City or Tow	n, State, Z	(ip Code	
2,	and ealth m 27		John Louis Dob	er, III/son		35 Garr					don, MD	210	09	
Baltimore,	ges 1 It of H If ite or ot		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 ☐ Removal from State	20b. Place of D	isposition (Nan crematory or ot	ne of ther plac	e) :	Da	ate	20c. Location	ı - City or ٦	Fown, State	<b>)</b>
ţ	t. Partmentant;		4 □ Donation 5 □ Other (Sp	pecify)	Atlanti					2009	Glen	Burni	e, Ma	ryalnd
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21 ignative Fundal Service Bryan W. 1	1 that		Lemmon 10 W.	ı Fur	ieral'	Home	of Di	ılaney V nium, M	Valle D 21	y Inc 093	•
			23a. Part 1. Enter the disease, or shook, or heart failure. List	co plication; that cause only one cause on each	ed the death. Do no line.								Approxir Interval	mate Between
	Physician		Immediate Caus (Final diseas or condition resulting in all ath)	304	iel Is	chem	ia						Onset a	nd Death
-	/Medical Examiner		resulting in at ath)	Due to (or as	s a consequence of)									
		<u></u>	Sequentially list conditions,	b	s a consequence of)									
V	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of highly that initiated events	Due to (or as	s a consequence or,	•						3		
7	execun and and ial-tra	Exal	that initiated events resulting in death) Last	C Due to (or as	s a consequence of)	:						$\rightarrow$		
8760-x	ficate be executed physician and s the burial-transit	dical		d.										
	tifica ng ph as th	ledi												
Вох	that the death certificed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2  Fetal death	3 ☐ Ectopic pr	reanano				23d. D	ate of deli	ivery	
О.	e dea he at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No		at time of death	5 Other (sp					N	vionth	Day	Year
<u>P</u> .	at the	P.	9 Unknown							T			.4	
Š,	es ign be	þ	Part II. Other significant condition	ns contributing to death t	out not resulting in th	ne underlying ca	ause give	n in Part I.			tobacco use coi Yes 2 □ No			
Ö	w requir	Completed									res Z INO	3 L	ODADIY 4	Oliknown
3ec	elaw hasl ge 2 s	ğ			.7					24a. Was	psy	prior to c	topsy findin completion o	ngs available of cause of
a	ician: Th certificate ector, pag		2-11							1 □ Yes	ormed?	death? 1 ☐ Yes	2 □No	
=		Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:			Othe			(Check only			-	
Division of Vital Records,	y Phy er this eral d	Ë	27. Manner of Death	28a. Date of Inj	ient 2 ER/Outp			7 🗆 1401			idence 6 🗆 O		cify)	
<u>.</u>	Attending It death. ector: Afte by the fune	텵	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ay, Year) Inju	iry M	Bc. Injury Work 1 □ Y	?¨ ′es 2 □ N						
Vis	Atte	iji	3 ☐ Suicide 6 ☐ Could not determine	ot be 28e. Place of In	jury - At home, farm tc. <i>(Specify)</i>	, street, factory,	office	2	28	Bf. Location	(Street and Num	nber or Ru	ral Route N	lumber,
<u> </u>	talor rsafte alDir edin	Certification: To	4 - Horniolde	ballaing, e	ic. (Specify)			•	19	City or 10	wn, State)			
· :	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best examiner: On the basis of and manner st	of examination and/	death occurred a or investigation,	at the tim in my op	ne, date and pinion, deat	d place, a th occurre	nd due to the d at the time	e cause(s) and r , date and place	manner as e, and due	stated. to the caus	se(s)
;	To th Comp	Me	29b. Signature and title of certifier	. 1	P	29c.	License	number			29d. Date sign	ied (Month	n, Day, Year	r)
			Simon	· c · u /	ora		RE	50	00	Ó	11/2	13/	200	, 9
			30. Name and address of person v	who completed cause of	, , , ,									
			DR SIMON I		9000 FI	RANKLI	nso	Quar	· e 1	DR 1	BaLTO	Md	212	137
	Stat Registra		31. Date filed (Month, Day, Year)		rar's Signature	bare	•							

09-09210	
Jorge Delcid	

Jorge Delcid	State of Maryla 1- For State Registrar	and / Department of Certificate of			g. No. 200	9 3777
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)			2. Date of Death Month November		3. Time of Death
moulou: Examino:	Jorge Francisco Delcid  4a. Facility Name (if not institution, give street and nu	mber) 4	b. City, Town, or Location of De		27, 2009 4c. County of Death	0433 hrs
	3 Hathaway Road		Lutherville Timonium		Baltimore Cou	•
Funeral Director	5. Social Security Number 6. Sex 218-63-0128 1 M 2 F	7. Age (In yrs. last birthday)  41 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Ars. 8. Date of Birtl	(MM/DD/YYYY) 9. Birth Foreign 25, 1968 Cou	Polace (State or FISalvador Intry)
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show any must be notified at once.	MD Baltimore	Timonium				1 Yes 2 X No
the Maryland a or 28a-f sh tified at once	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	•
with th	3 Hathaway Road  11. Marital Status   12. Was Dec	edent Ever in U.S. 13. Was	21093 Decedent of Hispanic Origin? (	Specify Yes or No-	El Salvado	
er death with 1 , or items 23s r must be not Funeral	1 X Never Married 2 Married Armed Fo		s, specify Cuban, Mexican, Pue		White, etc.	arr maidri, bidon,
rs after ural", miner	Widowed 4 Divorced If Yes, Give Yea     or Dates:  15. Decedent's Education (Specify only highest grade)		Yes 2 No specify: 's Usual Occupation (Give kind o		<del> </del>	alvadorian
5 72 hou al Exa	Elementary/Secondary (0-12) College (1	during mo	ost of working life. DO NOT use i		16b. Kind of Business/Ir	ndustry
5-0036 ed within 72 hour 15/15giene whatu the Medical Exan	6 N/A	Presse			Clothin	3
215- be filed mtal Hyg riked of ent, the	17. Father's Name (First, Middle, Last)  Francisco Lemus		18.Mother's Na Maria	me (First, Middle, M <b>Belcid</b>	aiden Surname)	
	19a Informant's Name/Relationship (Type, Print )  Carlos Anival Delcid	1	Address (Street and Number of	or Rural Route Numb		
eand 2 stealth a tem 27 traum:	Carlos Anibal Deleio/Nep 20a. Method of Disposition	hew 710 Mi	1ford Mill Roa	d Baltin	nore, MD 21.	208
more	1 Burial 2 Cremation 3 X Removal from		er place) De	cember	San Miguel	,
Baltin permit. P. Departmes Importan injury or	4 Donation 5 Other Specify: 21. Signature of Euneral Septice Licensee		ame and Address of Facility Imon Funeral Ho	, 2009	E1 Salv	vador T
Physician	Michael  23a Part Enter the disease or complications that ca	O. TIARIC     ()	w. radonia koa	d Timoni	11m MID 21(1)	93
/Medical	failure. List only one cause on each line.	ethanol intoxi		or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		consequence of):	Cation			
ler		consequence of):				
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that intuated events resulting in death) Last  Due to (or as a	consequence of):				
50, te be executed systician and burial - fransit	d			0 0 10 0 ==	···	
so, e be execu ysician and burial - trz	E EFALALE	23a,27,28a-f,p tem#18,19a,perFH,C	erm, E 8898 12/ 898,12/f/09,WS	30/09 TT		
cath certificate eath certificate a stending phy for use as the resician/M	3b. Was decedent pregnant in the past 12 months?	2	al death 3 Ectopic preg	nancy	23d. Date of delivery  Month D	ay <b>Y</b> ear
D. Box 6876 the death certificat by the attending phy ched for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		er (Specify)			
	Part II. Other significant conditions contributing to	death but not resulting in the un	derlying cause given in Part I.	23e. Did tob	acco use contribute to t	ne cause of death?
rds, P.C requires that been signed should be deter				-	2 No 3 Prob	
Records, The law requires ficate has been sig page 2 should be Completed				24a. Was ai autops perform	y prior to co	opsy findings available ompletion of cause of
of Vital Records, ng Physician: The law requin ufter this certificate has been si neral director, page 2 should t  T O Be Completed	25. Was case referred to medical		26.Place of Death (Chec	1 <b>✓</b> Yes 2		2 No
Vital hysician this cert al directo	100 2 100	patient 2 ER/Outpatient	IOther ==		esidence 6 🗸 Other:	Scene
드튜글스큐니하니	27. Manner of Death 28a. Date of (Month,	Day,Year)	1 Yes 2X No	28d. Describe ho	ow injury occurred	
Division or optial or Attending ours after death. Instal Director: Aft. Ifilled in by the fune. Certification:	2 Accident Investigation Fd 11	/27/09 Fd 4:15 of Injury - At home, farm, street	am		reet and Number or Run	al Route Number City
Div Spital o	4 Homicide determined (Specify)	house		Timoniu	reet and Number or Rur ate) 3 Hathawa M MD	y Rd
©   65 2 2 2 3 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Pa. Certifier 1	examination and/or investigation	ed at the time, date and place, a on, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as state	d. cause(s)
Py = = = = = = = = = = = = = = = = = = =	9b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
	Multiplication of person who completed cause	of death (Hom 22-)	O.C.M.E.		November 27, 20	09
	Margarita Korell MD. Assistant Med		nn Street, Baltimore, MD	21201		
State Registrar	11. Date filed (Month, Day, Year) 32 Reg	istrar's Signature	W.			
DHMH 17 Rev 1/2001	NOA 9 th mana Active	ORIGINAL				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g897 li-30-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Maggie Mae Dempsey 1:00 a<sup>™</sup> 11 25 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1300 Tab Street Odenton er 1 Year | If Under 24 Hrs. Anne Arundel If Under 1 6. Sex 8. Date of Birth (Month, Day, Year) 12/20/1926 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 🕱 F Yrs. Indiana 312-24-0771 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No 0denton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1300 Tab Street 21113 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Purchasing Supervison Government 18. Mother's Name (First, Middle, Maiden Surname)

Maggie
Elizabeth
Dento 17. Father's Name (First, Middle, Last) Charles Rainey Denton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, MD 21113 <u> Linda Corbin / Daughter</u> <u>1300 Tab Street</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory Woodbine, MD 21. Signature of Funeral Service Licensee Porota Marshall 22. Name and Address of Facility Maryland Cremation Services P.O. Box 1413 Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Put to (or as a construence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕱 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner Records, P.O. Box 68760€ Division or Vital

burial-transit attending physician for use as the burial as the ed by the a been signed be should be deta page 2 s has certificate this To the Funeral Director; After th completely filled in by the funeral To the Hospital or Attending death. within 24 hours a To the Funeral I

**Physician** 

/Medical

**Examiner** 

10a. State

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Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

29a. Certifier

29b. Signature and title of certifier

**Funeral** 

Director

f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Magnee.

**Physician** 

filed within 72 hours after Hygiene.

Maryland 21215-0036

Baltimore,

Medical

State Registrar

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Jear)

mo

Viterary May

32. Registrar's Signature

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D57531

Sente 204 millersulle sis

29d. Date signed (Month, Day, Year)

November 25,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** DAVID /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Randallstown Season's Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ★M 2 ☐ F 104-40-6120 54 09/23/1955 NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Windsor Mill 1√2Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1707 Chesterton Road 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married ģ 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked/ Handicapped N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Francis Donahue Marie Osborne ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel F. Donahue / Brother 11 West Parsons Ct., Setauket, NY 11733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 11/29/2009 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to jor as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 No 1 □Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only ne) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Injury 28a Date of Injur 28c. Injury at Work? 28d. Describe how injury occurred Watural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Examiner burial-tran P.O. Box 68760, attending physician for use as the buria signed by t t be detach Records, page 2 should Jas certificate Division of Vital To the Hospital or Attending Physician: this After t hours after death, within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical þ Completed Be Certification: To Medical

**Funeral** 

Director

s 23a or 28a-f show rust by notified at

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Heath and Mental Hygiene. ordant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, m. Profice Exemple 10 in 10 to

permit. Pages Department of Important: if it any injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0036

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State Registrar

DHMH 17 Rev 1/2001

Orran 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

BOB MD 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g897 11-30-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GENESIS HEALTHCARE-RANDALLSTOWN RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours Months 1 □ M 2**XX** 217-20-5586 86 10/12/1923 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No TURNER STATION MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 103 GLENARD MIDDLETON CT. 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: 3 ☐ Widowed 4 📆 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 HOUSEKEEPER HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROBERT MACKLIN, SR. GARNETT POWELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL A. JONES/DAUGHTER 1100 CEDARCROFT RD. BALTIMORE, MD 20b. Place of Disposition (Name of Mt Cemetery crematory or other place)

GEDAR HILL CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/09 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oronar Due to (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 DN 25. Was case referred to e ical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 40 1 Inpatient 2 ER/Outpatient 3□ D0A 27. Manne Death 28d. Describe how injury occurred

Physician /Medical Examiner

**Physician** /Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Department of Important: If it any Injury or o

72 hours after

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division or Vital Records,

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Examiner burial-transit attending physician Physician/Medical the as asn for signed by the a þ Completed page 2 s funeral director, Be P After this Certification: To the Hospital or Attence within 24 hours after death To the Funeral Director:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 ☐ Pending investigation Injury 1 🗌 Yes 2 🗌 No

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

Tingment

1 Li atural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number D47683 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Restriction MD

Kaymond Miller Man Strat Smle 25

State Registrar

Medical

32. Registrar's Signature 31 Date filed (Month, Day, Year) 3

	'	For State State Registrar	Cei	rtificate of	Death	Reg	. No 2 0 C	
Physic /Med		1. Decedent's Name (First, Middle, Last) Sharon Lee Dick		T		Month NovEMBE		3. Time of Death
Exami		4a. Facility Name (If not institution, give street and number)  ST. AGNES HOSPITAL			r Location of Death		4c. County o	f Death
Funera Director		5. Social Security Number 217-52-5238 6. Sex 1 ☐ M 2 ☐ 7. Age	(In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec 21	2009	9. Birthplace <i>(State or Foreig</i> Mary Land
Maryland -f show	tor	Usual Residence of Decedent	10c. City, Town or Lo	cation				10d. Inside City Limits
with the	l Direc	10e. Street and Number 6943 Washington Blvd.	0	10f. Zip Code 21075			j. Citizen of Wi	nat Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it it is Madical Evaning must be notified an once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces 1 Yes 2 N If Yes, Give Year or Dates:	_	Was Decedent of h If Yes, specify Cub 1 □Yes 2X No	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. white
Deficiency (Mary ylading ATA 13-0000)  bermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene.  mportant; if item 27 is marked other than "natural", or any injury or other traumatic event, its Medical Event any injury or other traumatic event.	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-12)	(Give	dent's Usual Occup kind of work done DO NOT use retire Ny techni	during most of work d)	ing	ib. Kind of Bus	Radiology
Janua Jid be filed v Vental Hygie rked other tic event, III	To Be Co	17. Father's Name (First, Middle, Last) George Foreman	TY Ite	iy ccomin		e (First, Middle, Ma		
INIAILY  1d 2 shou  1th and 1h  27 is ma		19a. Informant's Name/Relationship (Type. Print)  Edward C. Dick-husband			and Number or Rui			
Pages 1 ar nent of Hea ant; If Item ury or othe		20a. Method of Disposition  14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disponsion Competery, cree	sition (Name of natory or other pla	ce)	Date 20		City or Town, State
permit. Departimport		21. Signature of Funeral Service Licensee		2. Name and Address 19 Hammo	H			Home of Lanso e MD_21227
anth certificate be executed  Wedical  Wedical  attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	consequence of):	SHOC		or respiratory arres	и,	Approximate Interval Between Onset and Death Gays
the death certificate y the attending physiched for use as the l	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of the pregnant at 9 □ Unknown	2 ☐ Fetal death 3 [	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date Mon	e of delivery tth Day Year
uires that the de signed by the a		Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did toba		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknow
vical necolds, sician: The law requires t certificate has been signe irector, page 2 should be c	Completed by	Artery Disease, Hypertens	on, Hyper	-lipidemi	<del>,</del>	24a. Was an autopsy perform	24b. W	/ere autopsy findings availab rior to completion of cause of eath? □Yes
Physician: rthis certificaral director, p	Be	25. Was case referred to medical examiner?		Otl	or:	th (Check only one,		
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director; After this completely filled in by the funeral directorial directory.	Certification: To	27. Manner of Death  1	v 28b. Time o	f 28c. Inju Wo M 1 [	4 LI Nursing H	ome 5 ☐ Resider  28d. Describe how	injury occurre	
e Hospital or A 124 hours after e Funeral Direc		4 Homicide  determined  29a. Certifier (Check only  2 Medical Examiner: On the basis of	f my knowledge, deat	th occurred at the t		City or Town,	State) use(s) and ma	nner as stated.
To the Ho within 24 To the Fu	Medical	29b. Signature and title of certifier		29c. Licen				(Month, Day, Year)
,		30. Name and address of person who completed cause of de	eath (Item 23a) (Type.	Print)	21799	N	OVENBI	ER 21, 2000
S	tate	LAUREN TANEY, 900			BALT	imore,	MAR	YLAND 212
	trar	HOU O A BOOK	1	1				

Projected 1   December 1   December 1   December 1   December 2   December 2   December 3   De	egory Scott I	Den	1- For State	Si	tate of M	arylar	nd / Dep	partment of ertificate of	Health	and	Mental	Hygiene	9		009	37	778
46 CRUIT YEAR STATEMENT CONTRIBUTION MENDIOL CONTROL (FIGURE 2014)  5 STATEMENT CONTROL NAME OF THE CONTROL OF			1. Decedent's Nan			on							of Death		3. Tim	e of Death	
Unknown   Agreement   Agreemen			Baltimore V	Vashingtor			ber)	4			cation of De			4c. County of			
United Residence of Diceasers   The County Found of Losses   The County			unknown		1					$\overline{}$					9. Birthplace Country) Mary	(State or Forei	ign
The first item of shared processing from the state of the	yland -f show any once,	tor	10a. State MD	10b. County Anne	Arundel	L			nie								
Secret white  Se	ith the Mar 23a or 28a notified at	al Direc							21	.061			US		t Country?		
23. Part I. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardad or respiratory arrest, shock, or heart flamedate Cause (First disease). Due to (or as a consequence of):    Madicial Caminer   Committee   C	hours after death w 'natural'', or items Examiner must be	<b>全</b>	1 Never Marri 3 Widowed	4 Div	arried Ari 1 1 orced If Yes, G or Dates cify only highe	med Forc Yes live Year est grade	es? X No	If Ye	s, specify ( Yes 2 X	No s	lexican, Pue specify: (Give kind o	rto Rican, etc	o.)	White,	<sup>etc.</sup> White		G 12
23. Part I. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardad or respiratory arrest, shock, or heart flamedate Cause (First disease). Due to (or as a consequence of):    Madicial Caminer   Committee   C	5-0036 led within 72 tygiene. other than "	Complet	Elementary/Second 1:	(First, Middle,	Last)	lege (1-4	or 5+)	1					ddle, Maide		uction		_
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23. Part I. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardad or respiratory arrest, shock, or heart flamedate Cause (First disease). Due to (or as a consequence of):    Madicial Caminer   Committee   C	Itimore, N ii. Pages 1 and 2 ritment of Health ortant: If item 2 ry or other traus		20a. Method of Dis 1 Burial 2	position XCremation Other So	3 Remo	oval from	State	Place of Disposit crematory or other lantic C	ion (Name er place) remat	of cemet ory	ery, 11	Date -28-20	009 G1	Len Bur	nie MD	)	
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The part of the past 12 months?    The part of the past 12 months?   1			Sequentially list coi if any, leading to im cause. Enter Unde (Disease or injury ti	nditions, imediate rlying Cause nat initiated	Due to (c	oras a co	nsequence	of):									
Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy findings available prior to completion of cause of death?  1 yes 2 No  25. Was case referred to medical examiner?  1 yes 2 No  25. Was case referred to medical examiner?  1 yes 2 No  27. Manner of Death  1 yes 2 No  28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury	), be exect sician an urial - tr	dical			AMEN												-
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 21, 2009  State Registrar  WH 17 Rev 1/2001  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL	Box 6876 e death certificat the attending phed for use as the	hysician/M	23b. Was decedent past 12 months  1 Yes 2 N	? lo g Unki	nown g	Live birth Pregnant	at time of d	2 Feta		3	Ectopic preg	nancy	_  2		-	Year	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 21, 2009  State Registrar  WH 17 Rev 1/2001  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL	ds, P.O. equires that the seen signed by ould be detach	b	Part II. Other signif	icant condition	ons contribu	ting to de	eath but not	resulting in the un	derlying ca	use giver	n in Part I.	1	Yes 2	<b>√</b> No 3	Probably 4	Unknown	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 21, 2009  State Registrar  WH 17 Rev 1/2001  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL	al Recor	ψ.	25. Was case referre	ed to medical					26.6	Place of I	Death (Chec	1	autopsy performed?	prio dea	or to completion th?	on of cause of	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 21, 2009  State Registrar  WH 17 Rev 1/2001  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL	of Vita	유	1 ✔ Yes 2			піра			3 DOA	Oth	er: Nurs	ing Home 5					
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 21, 2009  State Registrar  WH 17 Rev 1/2001  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL  ORIGINAL	ision C Attending er death. rector: Aft	ication	1 Natural 2 ✓ Accident	5 Pendi	ng No	Month, Day 7 20, 200	v. Year) 09	1746 hrs	1	Yes	2 🗸 No	Pedestri	an struc	k by vehic	le		
29c. License number 29d. Date signed (Month, Day, Year) November 21, 2009  30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year) 32. Persistrar's Signature Registrar  OPIGINAL	Div Hospital or 24 hours afte Funeral Di	al Certif	4 Homicide	detern	nined (Spe	ecify) N	lajor Roa	d / Highway				SB Route	wn, State) 2 @ 6th	Avenue, Gle	en Burnie, M		
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  32. Desistrar's Signature  Registrar  OPIGINAL	To the within To the comple	Medic	2 🗸	Medical Exam	iner: On the b	asis of ex	xamination a	ind/or investigation	29c. Lid	nion, dea	ath occurred mber	at the time,	date and p	lace, and due	to the cause(		-
State Registrar  WH 17 Rev 1/2001  OCNE  ODIGINAL									<u> </u>				No	vember 21	, 2009		-
WH 17 Rev 1/2001		_							ireet, Ba		e, MD 21	201					-
AF 2006 UVITE URIGINAL			N	W 30 2	OCME	River	<del></del>	ORIGINAL							<del> </del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November Remzi M. Demir 2009 10:44 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7952 Cross Creek Drive Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Country)
Turkey (Month, Day, Year) 01/01/1927 1 🛛 M 2 🗆 F Months Days Min. Yrs. 82 5**1**4-40-9758 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Glen Burnie MD Anne Arundel 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A. 7952 Cross Creek Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White ☐ Yes 2 X No Specify. Specify: "natural" 3 Widowed 4 Divorced Year or Dates ed other than "natue event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked ဂ္ Mehmet Demir Serife f Health an m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7952 Cross Creek Drive, Glen Burnie, MD 21061 Sunny S. Demir/Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 K Cremation 3 Removal from State 11/25/2009 Ardent Cremation Services Hanover, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) m 0 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the s should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be

**To the Hospital or Attending Physician**: The law requires that the death certificate be executed P.O. Box 68760 Records, Division of Vital 24 hours after death. Funeral Director, Al filled in by сотретер

> State Registrar

Medical

4 Homicide

29a. Certifier

(Check

only one 29h Signal

31. Date filed (Month, Day, Year,

determined

30

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			1 - For State Registrar	State of Ma	ryland	d / Depa <i>Cer</i>	rtment of F	lealth a <i>Death</i>	ınd Me		iene g. No.		37	780
	Physicia	an	Decedent's Name (First, Middle						2.	Date of Deat Month	h Day	Yeer	3. Time of	
,	/Medic		Damion Dale							ovember	1	, 2009		0 A <sup>M</sup>
Ī	Examin	er	4a. Fecility Name (If not institution,	- Carrier			4b. City, Town, o		f Death			county of Dea		
			Hospice of Ches		(In vrs I	ast birthday)	Linthio		24 Hrs. R	Date of Birth	1			or Foreign
	Funeral Director		220-82-9431	1 kg M 2 □ F	48	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, 4/7/196	Year)		rthplace (State of country) nnsy lva	
	ס		Usual Residence of Decedent							1, ,, 15				
	how	_	10a. State 10b. County	-	-	, Town or Lo	cation						10d. Inside C	•
	Ba-f	cto	MD Howa	ard	EIK	kridge								2 <b>⊠</b> No
	with th	Funeral Director	10e. Street and Number				10f. Zip Code	-		1	_	en of What C	country?	
	sath y	erai	7132 Stone Thi	12, Was Decedent B	ver in 11	S 13 V	2107!		sin? (Specif	v Yes or No-		S.A.	erican Indian,	
	lter d	-un-	11. Marital Status  1 ☐ Never Married 2 ☑ Married	Armed Forces?		. is.	Vas Decedent of h f Yes, specify Cub	an, Mexican,	, Puerto Ric	can, etc.)		Black, Wh		
3	urs a	þ	3 Widowed 4 Divorced	ed 1 ☑ Yes 2 □ N If Yes, Give Year or Dates:			I∐Yes 2⊠No	Specify:			5	Specify:	White	
5	72 ho	Completed	15. Decedent (Specify only highes			(Give	lent's Usual Occup	durina most	of working		16b. Kin	d of Busines	s/Industry	
7	dhin n n	npie	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	DO NOT use retire	d)			П-	- 1 C		
7	tygier ther th		12 17. Father's Name (First, Middle, I	l act)		<u></u>	Baker	18 Mother	r's Namo (F	First, Middle, M		od Ser	vice	
<u> </u>	ntal h	Be	John	Peter		Di	ıgan	Kath		-ii St, Wilduid, I	Jun		Nel	son
<u></u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Indexted other than "natural", or items 23a or 28s-f ehow umatic event, the Madical Examiner must be notified a	ဥ	19a. Informant's Name/Relationsh				g Address (Street		-	Route Number				
_	and 2 salth a n 27 is		Alison Dugan/	Wife		7132	Stone I	hrow V	Way,	Elkrid	ge, i	MD 210	75	
ע	ss 1 a of Hei itam othe		20a. Method of Disposition	- FID	20b. PI	lace of Dispo	sition (Name of natory or other pla	ce)	Date	9	20c. Loc	ation - City o	r Town, State	
	Pages nent of I ant: If its ury or o		1 ☐ Buriat 2 ☐ Cremation 4 🙀 Donation 5 ☐ Other (Sp			-	ts Registr		11/24	/2009 I	Hano	ver, M	laryland	1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependentent of Health and Mental Hygiene.  Important: If tam 27 is marked other than "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at ORGS.		21. Signature of Femerat Service I	License		75	. Name and Addre	ss of Facility	Anato	omy Git Ste. P	Ets , Ha	Regist nover,	ry MD 210	76
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death	n. Do not ent	er the mode of dyi	ng, such as o	cardiac or r	espiratory arri	est,		Approxima tnterval Be	ite itween
1	Physician		Immediate Cause (Final disease or condition	Mer	L02	bah.	K.d.	DPAD	Cur	145			5 mc	Death
	/Medical		resulting in death)	Due to (or as a	a consequ	uence of):		109		10.01			J 41 )C	
	Examiner	_	Sequentiatly list conditions,	b										
	ed sit	Examiner	Sequentiatly list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	Jence of):								
•	xecul and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequ	uence of):								
2	cate be executed bhysicien and the burial-transit	dicai E		d										
0	ifficat g phy as the	edic		7									<u> </u>	
5	h cer endin r use	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnanc	v			2	3d. Date of d		
	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (specify)					Month	Day	Year
ć	het th d by detach		Part II. Other significant condition	MS contributing to death by	it not resi	ulting in the u	nderhing cause an	en in Part I		23e. Did tol	nacco us	se contribute	to the cause of	death?
Ď,	signe d be d	d by	Tarris Other signment contains	The contributing to death bo	20110011030	aning in the di	idenying cause gr	on in raci.		1 🗆 Y		4		Unknown
2	v requ	ete								24a. Was a		24h Wara	autopsy findings	available
ב ב	The lav	Completed							<del></del>	autops	ned?	prior to death?	completion of	cause of
	an: T tificet tor, pa	0	25. Was case referred to medical					26 Place	of Death ((	1 □ Yes : Check only on	2 No	1 TY		
>	ysicii is cer direct	To B	examiner? 1 ☐ Yes 2⊋ No	Hospitat: 1 ☐ Inpatie	nt 2 🗍	ER/Outpatier	t 3 DOA Ot	100		5 🗆 Reside			211	2.21
5	ng Ph ter th neral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of trijur (Month, Day	y Year)	28b. Time of	28c. Inju	ry at	280	d. Describe ho	ow injury	occurred	110	100
2	endli eath. or: A the fu	catic	2 Accident investig	pation			M 1	Yes 2 1	No					
	s efter d i Direct id in by	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		ury - At ho c. <i>(Specif</i> y	ome, farm, str /)	eet, lactory, office		281	f. Location (Si City or Town		l Number or i	Rural Route Nur	mber,
	To the Hospital or Attending Physician: The law within 24 burus elter death, within 24 burus elter death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 and page 2.	edical (	29a. Certifier (Check only one)  Certifyin 2 Medical i	g Physician: To the best of Examiner: On the basis of and manner sta	examinat	wledge, deat tion and/or in	n occurred at the ti vestigation, in my	me, date and opinion, deat	d place, and th occurred	d due to the c at the time, d	ause(s) ate and	and manner place, and d	as stated. ue to the cause(	(s)
	within To th comp	₩e	29b. Signature and title of certifier		/ _	1	29c. Licens	se number			11	1	nth, Day, Year)	
)			Know	0/10	se,	1	2	1315	51		Vou	? wher	2020	009
			39: Name and address of person	who completed cause of de	eath (Item	123a) (Type,	Print)	22	00-	ive, G	10.1	Rica	n /2 11	161
	Sta	te	31. Date liled (Month Day, Year)	2000 32/Registra	ar's Signa	ture /	1 105	1) 260	JW "	MAZ	10 n	Od Bull	12716	04)
	Registr		MUAZO	Course Comme	v /	a. 190	ules							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2:38 AM erena lobbs NOVEMBER 21 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTI MORE ST. AGNES HOSPITAL 8. Date of Birth (Month Day Year) 2.19.1970 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 212-98-9403 1 □ M 2 🕻 F 39 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if fine 77 is marked other than "natural", or items or any injury or other trauments. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Baltimore **Funeral Director**  $\mathcal{D}$ undalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 270No Specify: <u>۾</u> Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
file. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Covege (1-4or 5+) Elementary/Secondary (0-12) ministrative Mary land 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Unk Be Nanc LOY ပ a. Informant's Name/Relationship (Type. Print) Route Number 19b. Mailing Address (Street and Number City or Town, State, Zip Code 1222 1703 Kichard Dobbs Husband Dundalk Holaview 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore 5 ☐ Other (Specify) 4 Donation 21. Sign Funeral Service Lice 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESRD **Physician** rend End disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Accident erebrovascu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) <u>P</u>.0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Mellitus Diabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No certificate 25. Was case referred to medical examiner? 1 □Yes 1 □ Yes 2. No Vital Arteru To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 XNo 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21229 9 AUREN 00 CATON TANE 31. Date filed (Month, Day, Year 32. Registrar's Signature State 3 0 2009 Registrar

OBBS

09-09151 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Angelo Dangerfield Amend State of Maryland / Department of Health and Mental Hygiene Per This 898, 127,0370 Mental Hygiene Certificate of Death 1- For State Reg. No Registrar Physician/ Decedent's Name (First, Middle,Last) 2. Date of Death November 25, 2009 Angelo Dangerfield 0627 hrs Medical Examiner 4c. County of Death, N/A 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death University Hospital Baltimore 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY Country) Months Davs Hours Min Director 220-31-8170 21 7/29/88 1 X M 2 Yrs Usual Residence of Decedent 10a. State 10b. County I0c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore Yes 2 No or 28a-f show other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2849 Spelman Road 21225 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces? Married African 2 X No Yes If Yes, Give Year 4 Divorced Widowed 1 Yes 2 X No specify: Specia American traumatic event, the Medical Examiner ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housing-Balt. MD 21215-0036 Laborer 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Angelo W. Dangerfield Be Doris Dangerfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Dangerfield/Mother 2849 Spelman Rd, Balt., MD 212225 21225 mportant; If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place Will Jon King Memorial PK 20a. Method of Disposition Date 20c, Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State 12/5/09 Balt. Cty, MD Donation 5 Other Specify 22. Name and Address of Facility Hari P. 21. Signature of Funeral Ser ice Licensee Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part I. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line een Onset and /Medical Death a. Gunshot Wound of Chest Immediate Cause (Final disease ¬xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? certificate 1 🗸 Yes ✓ Yes 2 No director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 / DOA Nursing Home 5 Residence 6 After this ဥ 1 Yes No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Nov 25, 2009 Subject shot Natural 0559 hrs Pending Yes 2 V No the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2800 Spelman Rd, Baltimore, MD determined (Specify) Local Street To the Funeral 4 Momicide 29a. Certifier 1 completely 241 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 26, 2009 30. Name and -dd ess of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

State Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

Ling Li, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAVID DONALD **DVORAK** NMOVEMBERY 20, YEZIQ 2:50FM Medical 4c. County of Beath timore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 12-21-1943 Days Hours Min. 1**X** XM 2 □ F 214-44-0888 65 MARYLAND Director Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director Examiner must be notified 28a-f MD HARFORD ABERDEEN 1 Tyes 2 No 10e. Street and Number
233 FOREST GREEN ROAD 10f, Zip Code 10g. Citizen of What Country? 5 21001 should be filed within 72 hours after death with and Mental Hygiene. Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married XXMarried 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. ģ 1 ☐ Yes 2 ☐XNo Specify: Specify WHITE 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) SALES TAILORING Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, CHARLES **DVORAK** ROSE (WITT) 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau CHARLOTTE DVORAK/WIFE 233 FOREST GREEN ROAD 21001 ABERDEEN, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 11-24-09 BALTIMORE, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day 9 Unknown g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? 1 Yes 2 No prior to completion of cause of death? 1 Yes 2 No Be

Examiner and attending physiciar The law requires that the death certificate be Box 68760 After this certificate has been signed by the funeral director, page 2 should be detached P.0. Division of Vital Records, • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate b completed filled in by the

၉

Certificate:

Maryland 21215-0036

Baltimore,

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-20-00

D30263

TOWSON, MARYLAND 21204



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE FRANCIS KHOO. M.D.

31. Date filed (Month, Day, Year)

NOV 3 n

32 Registrar's Signature parket

State

Registrar

			1 - For State Registrar	State of	Maryland /	-	rtment of I			/lenta		ene g. No. (	009	37784
15			Decedent's Name (First, Middle,	Last)							of Death	)		3. Time of Death
	Physic /Medi		Eloise				Dalto	on		NO		Day 2	Year	1:45 PM
1	Exami		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, o	or Location	of Death		<u> </u>	4c. Cou	nty of Death	
1			Levindale Nur	sing Hom	ie		Balt	timor	ce					
	Funeral				Age (In yrs. last i		If Under 1 Year Months Days		24 Hrs. Min.	8. Date	of Birth	Year)	9. Birth	place (State or Foreign
	Director		216-24-9718	1□M 2 <b>X</b> F	82	Yrs.				06	22	27		WV
	pug 3		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation							10d. Inside City Limits
	laryla sho	ō												1 XYes 2 No
	the Marylar 28a-f show notified at	Director	MD NA 10e. Street and Number		-	ватс	imore				10	a. Citizen	of What Cou	intry?
	with ga or t be		2053 North Ber	talou St	reet			1216				_	U.S.	*
	ns 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. W	as Decedent of P Yes, specify Cub		rigin? (Sp	pecify Yes	or No-		Race - Ameri	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Fhealth and Mental Hygiene. them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1  Yes 2 If Yes, Give Year or Date	<b>X</b> No		Yes, specify Cub □Yes 2kkg No			o Rican, e	tc.)		Black, White,	, etc. lack
21215-0036	n 72 hou "natura edical E	Completed	15. Decedent' (Specify only highes	grade completed)		(Give k	ent's Usual Occu ind of work done O NOT use retire	durina mo:	st of wor	king	1	6b. Kind of	Business/Ir	ndustry
12	withi iene. than	E C	Elementary/Secondary (0-12)  9th grade	College (1-4	or 5+)		mestic	,	cer				Priva	ate
9	filed Hyg Sther ent, t		17. Father's Name (First, Middle, L							ne (First, I	Aiddle, M	laiden Surr		
Maryland	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the M	To Be	Joe Dalton					Hele	en I	hom	pson	ì		
ary	shound Mind Mind Mind	-	19a. Informant's Name/Relationsh	ip (Type. Print)	1:	9b. Mailing	Address (Street	t and Numb	er or Ru	ral Route	Number,	City or Tov	vn, State, Zi	p Code) 21216
	nd 2 alth a 27 is		Delores McMon	ris-Sist	<b>I</b>		North							
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other pla	ace)		Date	2	0c. Locatio	n - City or T	own, State
E	Page nent c int: if		1 Nation 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate		orial	1	11/	/28/	ว9 โท	loodl	awn.	Md
alti	permit. Pag Department Important: if any injury o		21. Signature of Funeral Service L	icensee	Ring	22.	Name and Addre	ess of Facil	ity	20,			15	
m	Depar impol any ir		Smette	K. Ime	2)	Ma 43	rch F/1 00 Waba	H Wes	st Ave	Ba	1 <b>+ i</b> m	ore.	БМ	21215
100	77.1		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cau	sed the death. D									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		G CAN	CFI	2							Onset and Death
1	/Medical		resulting in death)	d.	as a consequenc									
	Examiner		0	h										
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequenc	ce of):								
¥	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c										
ó	e exe lan a urial-l	Ĕ	resulting in death) Last	Due to (or	as a consequenc	ce of):								
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9	ertific ing pl	Med	IF FEMALE:											
Вох	leath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal dea	ath 3 □I	Ectopic pregnanc	у					Date of delive	very Day Year
0	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	nt at time of death n	5 🗆	Other (specify) _						monu,	Day Four
Ρ.	res that the de signed by the a be detached to	Ph	Part II. Other significant condition	ne contributing to dogs	h but not reculting	a in the un	dorlying cause gi	von in Bort		236	Did toh	3000 1180 0	antributa ta	the cause of death?
Division or Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by	CORDNARY	ARTERY	DISE	ASE	, ,			236	1 □ Ye			11
င္ပ	has be	ple	CITRUILIC ,	RESPIRA	TORY	FAL	LURE			248	. Was an		b. Were aut	opsy findings available ompletion of cause of
<b>E</b>		mo;								10	perform		death? 1 ☐ Yes	2 □ No
ita/	rtific tor,	Be	25. Was case referred to medical examiner?					26. Plac	e of Dea	th (Check				
<u>-</u>	nysici nis ce direc	To	1 Yes 2 440	Hospital: 1 1 mp	atient 2 ER/0	Outpatient	3□ DOA Ott	her: 4□N	ursing H	ome 5[	Reside	nce 6 🗆	Other (Spec	ify)
n 0	ding Ph n. After th funeral		27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of (Month,	Injury 28t Day Year)	b. Time of Injury	28c. Inju Wo	iry at ork?		28d. Des	cribe ho	w injury occ	curred	
Sio	Attending or death. ector: After by the fune	atic	2 ☐ Accident investig	ation			M 1	]Yes 2	]No					
Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zee. Place of	injury - At home, , etc. (Specify)	farm, stre	et, factory, office				ation (Str		mber or Rui	ral Route Number,
	itai o irs aff rai D	Se	12											
λ	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physiclan: To the be xaminer: On the basi and manne	is of examination	dge, death and/or inv	occurred at the t estigation, in my	time, date a opinion, de	nd place ath occu	, and due irred at the	to the ca	use(s) and ate and place	manner as ce, and due	stated. to the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier				29c. Licen:	se number			29	d. Date sig	ned (Month	, Day, Year)
			John H. W.	PLDEHIWOT			D00	6332-	7		N	ov. 2:	3,200	9
7			30. Name and address of person v			a) (Type, F	rint)							
			GIRAW WOLDE	HIWOT, M	0 2434	W. B	BELVEDE	RE	AVE	, m	DB	ALTIM	ORE	21215
	<sub>o</sub> Sta	ate	31. Date filed (Month, Day, Year)	32/Reg	istrar's Signature									
	Regist	rar	NOV 30	LUUY Ceta	ur S.	63	All I							

DHMH 17 Rev 1/2001

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Amend 19a-b, per Fh g898 12/22/09 TT

State of Maryland / Department of Health and Mental Hygiers A A Q

1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 26, **Physician** MARTHA ANNA DILLHOFER DICKEY 2009 9:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EDENWALD RETIREMENT COMMUNITY Baltimore County Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 2, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2√2 F 217-07-5394 95 Director 1914 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumetic svant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore County Towson 10e. Street and Number 10g. Citizen of What Country? death with 800 Southerly Road 21286 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) buld be filed within Mental Hygiene. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>2 yrs</u> Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked o permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumetic average. Joseph Mathias Dillhofer Grace Irene Yeatman 2 198 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter <del>5937</del> Seabright Road, Springfield, Virginia 22152 (Husband) Susan D. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 12/2/2009 Pikesville, Maryland 21. Signatura (Funeral Service Lebes) Arttin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. auso 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-stage congestive heart failure **Physician** /Medical Examiner atral Ebrillation Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò disease 2 No 3 Probably 4 Unknown 1 Tyes Completed destruc 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 **2** No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Tursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attanding Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarel C Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) gleher CRNP 29d. Date signed (Month, Day, Year) R154032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, MD 21286 Susan Scherr CRNP 800 southerly Road 37. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08170 State of Maryland / Department of Health and Mental Hygiene Richard D. Ehrhardt, Jr 2009 37786 1. For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day October 21, 2009 1208 hrs Richard Dennis Ehrhardt, Jr. Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death N/A Baltimore Harbor Hospital 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** 5. Social Security Number Country) Min. Months Days Hours Director May 6, 1969 Arizona 227-35-8852 40 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a. State E, 1 Yes 2 X No Anne Arundel Brooklyn or 28a-f shov Marvland hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code notified at 808 Washburn Avenue 21225 United States items 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Ves <sub>Specify:</sub> White Yes 2 X No specify: Widowed 4 Divorced f Yes. Give Yeer 'natural". 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "r
injury or other traumatic event, the Medical E Assistant Manager Restaurant 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard D. Ehrhardt Opal Blackwell Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₽ N Jean Ehrhardt/ Sister 7050 Pantego Drive Fayetteville, North Carolina 28314 20c. Location - City or Town, State October 28 2009 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Metro Crematory Donation 5 Other Specify: 22. Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee Inc. Maryland Alice Iser Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Head injuries complicated by tramadol intoxication xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, X UNPENDED ysician burial per ME g898 12/2/09 TT Box 68760. 23d. Date of delivery attending phys for use as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, his certificate has been s director, page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Nursing Home 5 Residence 6 Other: Inpatient 2 FR/Outpatient 3 DOA this 1 V Yes After th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 unk Division Natural Yes 2 X No Pending To the Funeral Director: completely filled in by the Fd 10/21/09 unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)  $808\ Washburn\ Ave\ Baltimore,\ MD$ 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide found in house (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

within 24 hours after death

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 22, 2009

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ivia	ır yıarıdı	•	rtificate of			Reg. No.	2009	37	1787
Př	nysicia	ın	Decedent's Name (First, Middle, L	ast)					2. Date of De Month	Day		3. Time o	n
	Medic		4a. Facility Name (If not institution, ga	Fred	Eva	ins	4h City Town o	or Location of Dea	11	22	2009 County of Deat	4:30	рм
) E	camin	er										n	
Fu	neral		415 N. Glove 5. Social Security Number 6.		(In yrs. last	birthday)		more If Under 24 Hrs	s. 8. Date of Bir	th	N/A 9. B <u>i</u> rt	hplace (State	or Foreign
	ector		215-76-3125	1 XM 2□ F	50	Yrs.	Months Days	Hours Min	8. Date of Bir (Month, Da	1959	) Co	untry) `	MD
p ,			Usual Residence of Decedent									1011	
aryla	in lat	2	10a. State 10b. County	N/A	10c. City, T	own or Lo timo						10d. Inside (	2 □ No
the M	ill ill	Director	10e. Street and Number	N/ A	Dai	CIMC	10f. Zip Code			10= Citie	zen of What Co		
E S	100	₫						2.4		-	S A	untry:	
leath	THE STREET	Funeral	415 N. Glover	12. Was Decedent E	ver in U.S.	13.	212 Was Decedent of H		Specify Yes or No		14. Race - Ame	rican Indian.	
3NG Z1Z13-UU35 be filed within 72 hours after death with the Maryland Hylgiene.	5	2	1 ☐ Never Married 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub I □Yes 2【 No	an', Mexican', Puè Specify:	rto Rican, etc.)		Black, White		
Z15-UU36 thin 72 hours aft e.	Audical	Completed	15. Decedent's E (Specify only highest gi	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kir	nd of Business/	Industry	
ZIZ ZIWith giene	I'm	E	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+	*	Di	sabled			Di	isable	d	
e filec	vent,	Be	17. Father's Name (First, Middle, Las					18. Mother's Na	ıme (First, Middle,	Maiden S	Surname)		
aryland should be file and Mental Hy	atic e	၉	Fred Evans		_			Marg	aret Jo	nes			
Maryland Z. Id 2 should be filed v Ifth and Mental Hygie 27 is marked other t	anma		19a. Informant's Name/Relationship		1		ng Address (Street					Zip Code)	
1 and 2 Health Health	her tr		Magdalen Eva	ns-Wife			. Curle		to, MD				
Daltimore, permit. Pages 1 ar Department of Hea	any Injury or other traumatic		20a. Method of Disposition  1   Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec				sition (Name of natory or other place d Park		Date -27-09		cation - City or t, MD	Town, State	
nit. F	ie jū	1	21. Signature of Euneral Service Lice		1.102		. Name and Addre		March E			-	
De la constant	any lr	1	& lead	. Wa					h Avenu			MD 21	202
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. [	o not ent						Approxima Interval Be	
Physic	cian		Immediate Cause (Final disease or condition			dic	NonSA	10/1 Ce	ellune	0	10	Onset and	Death
/Med			resulting in death)	Due to (or as a			1-6-10-	1 - 0 - 1	. ,	1	1100		
Exam			Sequentially list conditions.	b						)			
pe	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce oi).					İ		
xecut	l-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequent	re of):						li	
oo/ou, ificate be ex g physician a	as the burial-transit			- d		.,.							
00 tificat tig phy	as the	ed -		<b>L</b> C.									
ath cer	r use	an/k	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnanc	ev.		2	3d. Date of del	-	
De dea the at	funeral director, page 2 should be detached for use	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	· · · · · · · · · · · · · · · · · · ·			Month	Day	Year
that the	detac	=	Part II. Other significant conditions	contributing to death bu	not resulting	a in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of	death?
v requires to been signer	ld be	<u> </u>		S		9	- / 3		1 🗆 `	res 2[	]No 3□Pr	obably 4□	Unknown
w red	nous .	Completed						-	24a. Was	an	24h Were au	topsy findings	available
he la te has	age 2	Ĕ							autop	rmed?.	prior to death?	completion of	cause of
an: T	tor, p		25. Was case referred to medical					26 Place of De	1 □Yes eath (Check only o	2 11 No	1 ∐ Yes	2 □ No	
ysici is cer	direc	<u>n</u>	examiner? 1 ☐ Yes 2 🔽 ¥6	Hospital: 1 ☐ Inpatier	nt 2 ER/	Outpatien	t 3 DOA Oth	or:	Home 5 PResident		☐ Other (Spe	cifv)	-
ng Phy ferthi	neral	֡֟֝֟֝֟֝֟֝ <u>֚֚</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y Ye <i>ar</i> ) 281	b. Time of	28c. Injur Wor	ry at	28d. Describe I				
endir eath. or: A	he fi	iatio	2 Accident investigation	n	, , , ,	,,		Yes 2 □ No					
al or Att	d in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home (Specify)	farm, stre	eet, factory, office		28f. Location (; City or Tox	Street and vn, State)	d Number or Ru	ıral Route Nui	mber,
DIVISION OF VIGAL NECOLARY, F.C. BOX 80/00, S. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	letely fille	Medical C	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination	dge, death and/or in	n occurred at the tivestigation, in my o	me, date and place	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause	(s)
To the within	com	ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	e signed (Mont	h, Day, Year)	
			1 Dand State	meen m			D17.	7.07			11/25	2/09	
3	2		30. Name and address of person who	completed cause of de	ath (Item 23	a) (Type,	Print)	11 . A	-/ 2	01	MG	\	
	0		DAVID S. ETTING 31. Date filed (Month, Day, Year)	32. Registrar	's Signature	42 4	SKIHL	Mospil	69 13	CX C	2111		
Re	State gistra		NAV 3 a 2009	A.D.	1	bo. d	2						
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		1 - For State of Registrar					artment of I tificate of I		ene g. No. 2009 3 <b>7788</b>				
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Penelope Ellen Enye					Month	Date of Death     3. Time of Death				
	Examir Funeral Director	ier	4a. Facility Name (if not institution, give street and number)  Stella Maris Hospice  5. Social Security Number  506-62-0685  6. Sex 1 □ M 2 ▼ F  61			as <i>t birthd</i> ay) Yrs.	4b. City, Town, or Location of Death  Timonium  ay) If Under 1 Year If Under 24 Hrs. 8. Date of (Moonth, O5/0)				4c. County of Death  Baltimore  Birth Day, Year) 8/1948  9. Birthplace (State or Foreign Country) Nebraska		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent			10c. City, Town or Location  Annapolis  10f. Zip Code					10d. Inside City Limits 1 🏿 Yes 2 □ No		
			701 Glenwood Street, Apt. 7  11. Marital Status  1  Never Married 2  Married 3  Widowed 4 Divorced  12. Was Decedent Exammed Forces? 1  Yes 2  If Yes, Give Year or Dates.			ver in U.S. 13. Was Decedent of His If Yes, specify Cuban,			ispanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)			Citizen of What Country? U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White	
			15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)			(Give kind of work done during most of working life. DO NOT use retired)				Kind of Business Industry  Ninistrative			
			17. Father's Name (First, Middle, Last)  Clarence Trout  18. Mother's Name (First, Middle, Maiden Sur. Luella Welch						n Surname)				
			19a. Informant's Name/Relationship (Type, Heidi Swift/Daugh 20a. Method of Disposition		205 0	604			Rural Route Numb	apol:	is, MD	21401	
			1 ☐ Burial 2 🛣 Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	noval from State	Arde	emetery crem ent Crem	ation serv.		/24/2009 rdent Cre	Hai		Maryland	
8	ed m m on on on	8 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  7522 Connelley Drive, Ste.N, Hanover, MD 21076  Approximate Interval Between										
	Physician/ Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  END STAGE RENAL DISEASE  Due to (or as a consequence of):										
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hospital and redeath.  24 hospital affector: After this certificate has been signed by the attending physician and stead filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/	Sequentially list conditions, if any, leading to immediate cause. End of Understanding the cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d										
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of de Month	elivery Day Year			
	requires that to been signed by should be deta		Part II. Other significant conditions contri	outing to death bu	t not res	ulting in the u	nderlying cause gi	ven in Part I.	_ 1 🗆	Yes 2	2 X No 3 □ I	o the cause of death?  Probably 4 Unknown	
	ician: The law certificate has brector, page 2 s		25. Was case referred to medical examiner?		-		_26. P	ace of Death (C	per 1 🗆 Yes	s an opsy formed?	prior to death?	utopsy findings available completion of cause of	
	I or Attending Physician: 1 after death. Director: After this certifics I in by the funeral director, p	유	1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation 3  Suicide 6  Could not be	1 □ Inpatier 28a. Date of injury <i>(Month, Day,</i>	Year)	ER/Outpatien 28b. Time of injury	28c. Injur work M 1 □	4	g Home 5 Res 28d. Describe	how inju	iry occurred		
	spital or A lours after leral Direc filled in by		4 - Homicide determined	building, etc.	injury - At home, farm, street, factory, office etc. (Specify)  28f. Location (Street and Num City or Town, State)  of my knowledge, death occured at the time, date and place, and due to the cause(s) and mar						e)		
	To the Hospital or within 24 hours aff To the Funeral Discompleted filled in	Medical		On the basis of exa	mination	and/or investi	igation, in my opinio	on, death occurr e time, date and	ed at the time, date	and place he cause	e, and due to the	cause(s) and manner stated s stated.	
			30. Name and address of person who comp	leted cause of dea	ath (Item	23a) (Type, P	1314 rint)	9792			11 23 2	009	
	Sta Registra	e	JACKIE JONES, CRNE 31. Date filed (Month, Day, Year) NOV 3 0 2009	2300 D 32. Registrar			LEY RD.	TIMONI	UM, MD 2	1093	3		
DL	4H 17 Pay 7/00	100	1101		-	1 9						_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene2009Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 7555,6 Eaddy /Medical 2009 cility Name (If not institution, give street and number) Examiner or Location of Death 4c. County of Death 103 more If Under 1 Year | If Under 24 Hrs. bcial Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) 1 □ M 2 🗹 F Months Hours Min. 2 8-22-2810 Usual Residence of Decedent Yrs. Director nia filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced lack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked ott Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baito Heig other! permit. Pages f and Department of Healt Important: If item 2: any Injury or other I larence ack 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Park 11/28 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 1. 10 32 Ph 21. Signature of Fune al Service License Funexal, Home MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sec **Physician** Shock disease or condition resulting in death) 3 hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancel Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed? Yes 26 No 1 □Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner?
12 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No in by the 2 ☐ Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6626 VOI 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) abatabai Soultimore

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day,

Year)

2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

gar Allen Fin		State of Maryland / Department of Certificate of Registrar		Reg	No. 20	09 3779
Physici edical Exam	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month I November 2	Day Year	3. Time of Death 1129 hrs
CIICAI EXAIII	ner	Edgar Allen Fincham  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 2	4c. County of Deatl	
		8738 Rose Lane	Jessup		Howard	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min.	-1	(MM/DD/YYYY) 9. Bir Foreig	an l
Director		214-26-9998   1XM 2 F   80 Yrs		July 4	, 1929 c	ountry)Maryland
'n		Usual Residence of Decedent  10a. State 10b. County 10c City, Town or Local	ion			10d. Inside City Limits
nd how a	L	Maryland Howard Jessup				1 Yes 2 X No
farylar 28a-f s at on	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	·
the N 3a or 3	Dir	8738 Rose Lane	20794		Jnited Sta	
death with the Maryland or items 23a or 28a-f show any must be notified at once.	neral	1 Novemberried 2 Y Married Armed Forces?	as Decedent of Hispanic Origin? (Sp 'es, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amei White, etc.	rican Indian, Black,
(I) e L-	_	1 Yes 2 No	Yes 2 X No specify:		Specify: Wh	ite
ours al atural xamin	d by		nt's Usual Occupation (Give kind of votes of working life, DO NOT use reti		16b. Kind of Business.	/Industry
36 in 72 h nan "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Horsetrainer	,	Own Busine	
5-0036 filed within 72 Hygiene.	E O	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M		288
21215-0036 uld be filed within 72 Mental Hygiene. marked other than	Be (	Oscar David Fincham	Annie Cu			
D 21 should and Me	ို	(1,)	g Address (Street and Number or I Rose Lane Jessup			e, Zip Code)
and 2 lealth a tem 2 traum		20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery	Date	20c. Location - City o	r Town, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene and Department of Health and Mantal Hygiene and Important: for items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:  Metro Cre	ther place) NOV	ember 24,	3altimore,	Maryland
altin mit. P partme portar ury or						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Faculty Pemation Society 19 Frederick Road	Baltin	nore, Mary	land 21228 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	the mode of dying, such as cardiac o	or respiratory arre	SI, SHOCK, OF HEAR	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)  a Contact Shotgun Wound of Head  Due to (or as a consequence of):				
	_	Sequentially list conditions, b.	<del></del>			
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
N & E	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
so, te be executed system and shurial - transit	edical	d. UNPENDED AMENDED			-	
'60, ate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	,
30x 6876 death certificate te attending phy I for use as the I	ian/	past 12 months?	etal death 3 Ectopic pregn	ancy	Month	Day Year
Box 68760, re death certificate be the attending physic the attending physic end for use as the buri	Physician/N	1 Yes 2 No 9 Unknown g Unknown	ther (Specify)			
P.O. ss that the gned by the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute t	o the cause of death?
IS, P quires t en sign ald be o				24a. Was a		autopsy findings available
cord law red has be 2 shou	ompleted			autop: perfor	sy prior to	completion of cause of
Re( : The ificate r, page	0	DE Was and referred to reading	26.Place of Death (Check	1 Yes	2 No 1 🗸	Yes 2 No
/ital /sician vsician vis cert	o Be	25. Was case referred to medical examiner?  1   V   Yes 2   No	Other		Residence 6 🗸 Oth	ner: Scene
of Vital Records, P.C. ling Physician: The law requires that After this certificate has been signed funeral director, page 2 should be dete	-	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe h Subject shot	now injury occurred	
sion ttendi death.	atio	2 Accident Investigation Nov 21, 2009 1120 hrs	1 Yes 2 ✓ No			- 1 B - 1 N - 1 - 1 O''
Division of Vital Records, ours after deal or Attending Physician: The law require users after death.  In the property of the	Certification:	3 Suícide 6 Could not be determined (Specify) Townhouse / Rowhol			street and Number or I tate) ine, Jessup, Md.	Rural Route Number, City
ig of pi		29a. Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place, an	d due to the caus	e(s) and manner as st	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred	at the time, date	and place, and due to	the cause(s)
	ž	29b-Storiature and title of certifier	29c. License number		29d. Date signed (A November 22,	
		(aum)	O.C.M.E.	<del></del> .	November 22,	
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 2	1201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7 0 0			
Regi	strai	NUVOUS Chrown A. A.	and			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Maryland Poet PHYS G898 12/11/09 Wental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOK VOVEMBER 29 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** CAR VIEW AIR Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 10/06/1907 1 ☐ M 2 🕱 F 125-12-1558 102 Bermuda Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show 1 ☐ Yes 2 No Carroll Mt. Airy Director be notified 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. ō 4101 Old National Pike USA 21771 or items 23a must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status "natural", or Item edical Examiner r Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 No Maryland 21215-0036 Specify. þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Waitress Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Ledi (unknown) James Lori 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19032 Mills Choice Road, Montgomery Village, MD 20886 Minola Wilkerson / Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/30/2009 Final Journey Crem. Woodbine, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota, Marshall Approximate Interval Between Onset and Death Do not enter the mode of duing, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications the caused the death. shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be executed Due to (or as a consequence of): attending physician Records, P.O. Box 68760 Physician/Medical the for use as 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 1 ☐ Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No Division or Vital Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient ပို 1 Inpatient within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral to 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29ç. License number 29b. Signature and fittle of certifier 80. Name and addless of person who TORDOW IN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

LyKeisha Freeman 09-08937 Plea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nk Unk		State of Maryland / Department of Health an  Certificate of Death	nd Mental H		2.0	00 0770
Physici		1. Decedent's Name (First, Middle,Last)		Reg. I	-	3. Time of Death
ledical Exami	ner	Lykeisha Freeman		Month Da November 17	y Year 7, 2009	1600 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, o  934 East Eager Street  Baltimore	r Location of Death	1	4c. County of De	ath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes 212 90 3998 1 Months Day			For	Birthplace (State or reign Country) Md
ž		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ow any						1 Yes 2 No
Maryland 28a-f show 1 at once.	ctor	Md Baltimore Cit.  10e. Street and Number 10f. Zip Code	<u>Y</u>	10g.	Citizen of What C	41
the Ma 1 or 28 iffed 3	Director	2123			USA	
MD 21215-0036 2 should be filled within 72 hours after death with the Maryland h and Montal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she smattle other than "natural", or items 23a or 28a-f she smattle event, the Medical Examiner must be notified at once	ıral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi	ispanic Origin? ( Sp		14. Race - An	nerican Indian, Black,
or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuba		Rican, etc.)	White, etc	· distribution
s after iral", niner	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No.  15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupa			Specify: B1	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)			io. Kind of busine	ss/industry.
036 thin 7 ne.	nple	9 unemploye	d			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Surname)	
121 d be fi ental I arked	Be	Russell Freeman		ra Duva		
MD 2  Id 2 should  If and M  m 27 is m  aumatic c	ဥ	19a. Informant's Name/Relationship (Type, Print)  Russell Freeman  father  212 s Ball				ate, Zip Code)
and 2 lealth tem 2 traun		20a. Method of Disposition 20b. Place of Disposition (Name of co	OU CT D emetery,	Date 2	21213 0c. Location - City	or Town, State
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and M Important: If item 27 is ninjury or other traumatic		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	m 11	30 09 <sub>T</sub>	oundalk	Мđ
altir mit. E partme porta ury or		21. Signature of Funeral Service Licensee 22. Name and Address	ss of Facility Ph			rford FS PA 1213
E E E	i.					1213
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.	,, such as cardiac o	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,				
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	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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O, e be executed ysician and burial - transit	edical	UNPENDED AMENDED				
ox 6876(eath certificate attending physeries as the b	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregna	ancy	23d. Date of deli Month	very Day Year
Box 6876  death certificate the attending phy ed for use as the l	icial	past 12 months?  4 Pregnant at time of death  5 Other (Specify)		ancy	WOTH	Day Teal
Bo)	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown				
i, P.O. B ires that the d signed by the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.			e to the cause of death?  Probably 4 Unknown
ds, I	ted			24a. Was an		e autopsy findings available
cords law required has been 2 should	Completed			autopsy performe	prior	to completion of cause of
tal Rection: The certificate ector, page	ပ်			1 <b>Y</b> Yes 2		Yes 2 No
ital sician is certi	å	examiner? [Hospital: 4   Innation 2   FR/Outsetion 3   POA	Other Nursin		sidence 6 🗸 O	ther: Scene
n of Viding Physi	. T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Inj	jury at Work?	28d. Describe hov		
ion (tendin eath.	ţi		Yes 2 🗸 No	Subject beater	1	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death.  reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined (Specific Manual Project of Injury - At home, farm, street, factory, office		28f. Location (Street or Town, State 936 East Eager	e)	r Rural Route Number, City
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b.		29a. Certifier (Check only one)  29a Certifier 1  29a Certifier 2  29a Certifier 3  29a Certifier 4  29a Certifier 4  29a Certifier 5  29a Certifier 7  29a Certifying Physician: To the best of my knowledge, death occurred at the time, one)	date and place, and	d due to the cause(s	and manner as	stated.
To t To t	Medical	and manner stated.	ise number			(Month, Day, Year)
			.M.E.		November 18	
		30. Name and address of person who completed cause of death (Item 23a)				
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Ba	Itimore, MD 21	1201		
	~~	31. Date filed (Month, Day, Year)  32. Pegretrar's Signature				
Regist	trar	NOV 30 2009 June S. Jack				
HMH 17 Rev 1/2	001	ORIGINAL				)CHE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 18, 2009  $P^{M}$ 7:50 November Royce Austin Fish 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1414 Stratton Drive Montgomery Rockville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 25, 1922 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 186<u>1192 urita 1</u>unizer 1 2 M 2 □ F 87 Yrs Pennsylvania 186-12-1314 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 1414 Stratton Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 XINo Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Broadcast Engineer Broadcasting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Shackleton George R. Fish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Stratton Drive, Rockville, Maryland 20854 Doris F. Fish/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date November 23. 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State Mt. Zion Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2005 Lymphoma-Diffuse and Recurrent disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? High Blood Pressure, Hyperlipidemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

/Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural"

Ith and Mental F 27 is marked ott traumatic even

Health a

permit. Pages 1 and Department of Heal Important: If item 2 any injury or other

other t

Funeral Director

2

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

21215-0036

Maryland

Baltimore,

**Physician Examiner** Box 68760,

The law requires that the death certificate be executed burial-tran cate has been signe page 2 should be

P.0.

Division of Vital Records,

Physician/Medical

Completed by

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Certification: To

cal

Medic

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director. After this certifica funeral director, the filled in by

State

Registrar

J6hn S. Saia, M.D. 31. Date filed (Month

5 Pending

investigation

determined

6 ☐ Could not be

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Check only

29b. Signature and title of certifier

1 X Natural

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

D10493

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

2 🛛 No

28d. Describe how injury occurred

1 □ Yes

Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify)

26. Place of Death (Check only one)

November 19, 2009

he and address of person who completed cause of death (Item 23a) (Type, Print)

1201 Seven Locks Road, #202, Rockville, Maryland 20854 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Nov 22. 2009 11:00 P Rosemary Agnes Feeney /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel 1816 Whites Ferry Place Crofton 8. Date of Birth (Month, Day, Year) Aug 30, 1937 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XX 72 Director 126.28.8650 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ire Madical Examinar must be notified at 1 TYes XX No Director MD Crofton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code within 72 hours after death with USA 1816 Whites Ferry Place 21114 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Saltimore, Maryland 21215-0036 1 □Yes XX □ No Specify: þ White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Clinical Manager Health Care Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Dell'Edera Mary 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 1816 Whites Ferry Place, Crofton, Md 21114 John Sterbenz Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Kremation 3 ☐ Removal from State 4 ☐ Donation Bayview Crematory Nov 25, 2009 Baltimore, MD 5 ☐ Other (Specify) 22. Name and Address of Facility
Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Gregory Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise shock, or heart failur ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final **Physician** YOU month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋧ 2 🗹 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a Was an has autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred † Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24-hours after deat Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

egistrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 29 aperDVR, G89 /, 11730 / 09 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Novem ane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Genesis Perring Parkway Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (St. Month, Day, Year) 9. Birthplace (St. September 12, 1920 Maryland 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 □ XF 212-09-8391 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exercitor roust by notified at Baltimore Maryland N/A 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21213 3643 Chesterfield Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White \$ 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Wladyslawa Klosek Stanislaus Sobotka ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 606 Red Oak Avenue Edgewood Maryland 21040 of Health a Jane A. McIntyre/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or one. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 11/30/09 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final trogressive decline in condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ischemic CARDIDMYOPAthy & EJECHICH Fraction 15% Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Large left Ventricular thrombus

Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi resulting in death) Last Box 68760, CORONARY ANTERY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mor Month Year Day P.O. 1 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ non-ST- Segment elevation myocardo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Kidney disease, 24a. Was an page 2 s autopsy performed? DYSLIPIDEMIA FAILURE to thrive 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 -NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2₽No Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation after death.

I Director: Af din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dex To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical XNurse Practic Concer stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Eutan Street Suite 321 MARULAND 21201 821 North 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month,

Back

BALTIMERE MARYLAND

MARCIAR, Soulsman,

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June Annette Gedden 2009 November 3:40 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. FutureCare North Point Eastpoint 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 □ M 2 🖵 F Months Days Hours Director Maryland 218-26-3309 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Swanton 1 Yes 2 No Maryland 10e. Street and Number Garrett 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 4190 Dry Run Road 21561 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 X Divorced Completed White Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freda Dora Pfisterer Milton Kraft, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janice A. Menear(Daughter) 4190 Dry Run Road Swanton, Maryland 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 12/3/2009 Dorsey, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 CONTO. 7922 Wise Dundalk, Maryland Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ MOLEYAU Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lor as a consequence of resulting in death) Last Due to (or as a consequence of): -leinnq physician s the burial Physician/Medical attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ icate has been sig ; page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be

that the death certificate be Box 68760 P.O. Records, or Attending Physician: The law requires Division of Vital within 24 hours after death

To the Funeral Director: /
completed filled in by the f Hospital

the

within 72 hours after

Maryland 21215-0036

Baltimore,

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dakwood

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

Registrar

3 Suicide 4 Homicide

31. Date filed (Month)

determined

rdon

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

E48.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary	•	rtificate of L		nemai my	Reg. No.2	009	37797
	Physicia	an	1. Decedent's Name (First, Middle, L	C 0 A				2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death			nty of Death	
<i>)</i>		Ÿ.		410	dial car	FACT If Under 1 Year	MUE If Under 24 Hrs.	8 Date of Bir	th	9. Birthr	place (State or Foreign
	Funeral Director		5. Social Security Number 6. 217 40 7862	Sex 7. Age (III 1 □ M 2 🖾 F 68	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da		Coui	yland
-			Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation					0d. Inside City Limits
Maryl	a-f sho	tor	Maryland Baltimo	ore	Essex						1 ☐ Yes 2 🗖 No
ith the	or 282	Director	10e. Street and Number			10f. Zip Code 2122	1		10g. Citizen	of What Coul <b>USA</b>	ntry?
eath w	ns 23a	Funeral	1245 Engleberth I	12. Was Decedent Ever	r in U.S. 13. \	Was Decedent of H		pecify Yes or No		Race - Ameri	
d 21213-0000 filed within 72 hours after death with the Maryland	al", or iter Examinat	2	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2X No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 □ Yes 2 🙀 No	Specify:	5 Ficall, etc.)	Spe	cify: Wh	nite
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d within	giene.	Omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Waitress				taurar	nt
pe ille	event	æ	17. Father's Name (First, Middle, La William Fredrick				18. Mother's Nam Elizabe	ne (First, Middle ≥th M. 1		name)	
12 should be	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modical Examiner must be rediffed at once.	은	19a. Informant's Name/Relationship Thomas W. Gray (	(Type. Print)	19b. Mailir 7117	ng Address (Street Baltimore	and Number or Ru	ural Route Numb Ltimore,	er, City or To	wn, State, Zi and 2	p Code) 1224
S 1 and	of Heal item 2 r other		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	ce)	Date		on - City or T	
Pages	tment tant: If		1 ☐ Burial 2 🕱 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	Bayview (					ore, 1	Maryland
Dall	Depar Impor any in		21. Signature of Funeral Service by	wikuske	. 14	2. Name and Addre ruzdzinsk 407 Old E	astern A	venue Es	ssex, M	laryla	
			23a Part1. Enter the disease, or concock, or heart failure. List of Immediate Cause (Final	omplications that caused the hy one cause on each line.	(	ter the mode of dyli	ng, such as cardiad	c or respiratory a	arrest,	J	Approximate Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	a. Due to (or as a c		:					
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uted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.	0110224401100 0171						
oo / ou, ficate be exec	physician and s the burial-transit	al Exa	resulting in death) Last	Due to (or as a c							
DO/	ng phys as the	ledical	15.55.40.5	d							
I RECORDS, F.O. BOX 007 00,	To the Fugura of Areatoning Trypholom. The fact of the action of the attending to the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent premant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at til 9 □ Unknown	Fetal death 3	☐ Ectopic pregnand	су		23d	Date of deli Month	very Day Year
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DIVISION	ter death. Irector: A	Certification: To	2 Accident investigate 3 Suicide 6 Could not determine	ation of be	- At home, farm, st (Specify)		Yes 2 □No		(Street and Nown, State)	lumber or Ru	ural Route Number,
ט יי	Funeral D	Medical Cer	29a. Certifier 1 Certifying (Check only one) 2 Medical E	p Physician: To the best of examiner: On the basis of eand manner state	xamination and/or i	ath occurred at the investigation, in my	time, date and place opinion, death occ	ce, and due to the	ne cause(s) ar e, date and pl	nd manner as ace, and due	s stated. e to the cause(s)
, t	within: To the	Mec	29b. Signature and title of certifier	and marrier other		29c. Licen	se number	/	1		h, Day, Year)
			I she Ad	- m		N6(	137675 BAX	2111	11 (25	3669	
			30. Name and address of person v	who completed cause of dea	Story (Type	LEEUE ST	BAT	MORE	MD	212	51
T	St Regist	ate trar	31. Date filed (Month, Day, Year)		s Signature	la S					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6.45 AM NOVEMBER 26 2009 Greene 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Days Hours Min. 1 M 2 □ F -26 229-18-3893 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Nes 2 No 10g. Citizen of What Country? 10e. Street and Number 21230 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Ma ried 2 Married 1 □Yes 2 ☑No Specify: 1ac 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Elementary/Secondary (0-12) College (1-4or 5+) estins hous 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Areene 19b. Mailing Address (Street and Number or Rural Route Informant's Name/Relationship (Type. Pr 20b. Place of Dispo Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Owings Mills MI) Greene Fineral Services 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee 13a/to, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 YEARS CORONARY ARTERY disease or condition resulting in death) Due to (or as a consequence of): GARS ONGESTIVE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2ZINO 1 □Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

2

Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modral Event here and be notified at once.

Baltimore, Maryland 21215-0036

the attending physician and hed for use as the burial-tran certificate has been signed by the rector, page 2 should be detached

Physician/Medical

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Hospital or Attending Physician: funeral director. After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 100 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

900 CATON AVENUE, BALTIMORE, MD 21229

26/2009

31. Date filed (Month, Day, Year)

Dr. ASHOKA INDUKURI,

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KESIDENT PHYSICIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies	
State of Maryland / Department of Health and Mental Hy	giene
Claric Cr. Ittell June 1 = -1	

y Rhoop Ghinghe	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No	
Physician/	ecedent's Name (First, Middle, Last)  2. Date of Death  Month Day Year 2 3 in el of Death  Month Day Year 2 13 in el of Death	77
dical Examiner	Guy Roop Gningner November 20, 2003	
	10921 Stang Road Owings Mills Baltimore County	- Coign
Funeral Director	9-50-1885 XX <sub>M 2</sub> <sub>F</sub> 61 Yrs. Months Days Hours Min. December 21,1947 Mary Land	reign
w any	al Residence of Decedent State 10b. County 10c. City, Town or Location 10d. Inside City Lin ryland Baltimore Parkton 1 Yes 2XXX	
the Maryland a or 28a-f sho tified at once.	Street and Number  1 Hillside View Road  10f. Zip Code 21120  USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Marital Status  Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  No  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
5-0036 ed within 72 hours after tygiene. other than "natural", o he Medical Examiner. Completed by F	Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify.  Decedent's Education (Specify only highest grade completed)  College (1-4 or 5+)    1	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Respiratory Therapist Medical Equipment  Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Maiden Surname)	
2121; nould be fill id Mental H is marked tic event, I	hn Jacob Ghingher Jr  Evelyn Janet Roop  Informant's Name/Relationship (Type, Print)  Informant's Name/Relationship (Type, Print)  PO1 Hillside View Road Parkton, Maryland 21120	
rre, MD s 1 and 2 sho f Health and If item 27 is	Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other triangury or other tr	Donation 5 Other, Specify:    Donation 5 Other, Specify:   GreenMount Crematory   Nov 25,2009   Baltimore, Maryland	
Physician /Medical caminer	Approximate Interest of disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each if e.  Mediate Cause (Final disease at Vanging	
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Sici pe	UNPENDED  AMENDED  23d. Date of delivery Was decedent pregnant in the  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	ar
). Box 68760 the death certificate by the attending physiched for use as the brokeician/Mo	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  9 Unknown  Unknown  2 Other (Specify)  2 23e. Did tobacco use contribute to the cause of death	th?
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Records, The law required ficate has been significate has been significate has been significated by the standard of the standa	24a. Was an autopsy findings ava prior to completion of caus performed? 1	No
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of Vita	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 ✓ Other: Scene  28a. Date of Injury  County Day, Year)  Prof. (North: Day, Year)	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the tours after death.  meral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	Natural 5 Pending Investigation  ✓ Suicide 6 Could not be Could not b	er, City
y fil	Homicide   Homicide	
To the He within 24 To the Fu completel	and manner stated.	
	by Signature and title of certifier  O.C.M.E.  November 21, 2009	
	Hame and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr	Date filed (Month, Day, Year)  32. Registrar's Signature	
MH 17 Rev 1/200	OCME ORIGINAL	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Month

November

22, 2009

12:40 A M

**Physician** /Medical **Examiner** 

Judith Carol Giuliano

4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery General Hospital 01ney Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🗙 F 217-36-7482 69 Director December 22, 1939 Washington, DC Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Prodical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4413 Muncaster Mill Road 20853 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced White Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Controller Staffing \$2 should be filed what and Mental Hygie
7 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Giuliano ၉ Helen Leland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar 20305 Brook Run Place, Germantown, Maryland 20876 Jacqueline C. Dillon/Daughter permit. Pages 1 an Department of Heal Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 24. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. Inth 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 4 hours Multisystem Organ Failure resulting in death) /Medical Due to (or as a consequence of): **Examiner** Urosepsis 10 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, physiciar pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) P.O. I ☐Yes 2XNo the detached 9 Unknown signed by the detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Upper Gastrointestinal Bleeding, Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ို 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day, Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 💆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fil Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0035045 November 22, 2009 30. Name and address of pe who completed cause of death (tem 23a) (Type, Print) Philip G. Henyum, M.D. 18109 Prince Philip Drive, #200, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 12:55 PM **Physician** 00 Charles Alvin German /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5. Social Security Number 6. Sex Med Ctv If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth September 192 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Sex 1- M 2 ☐ F Maynty Land Funeral Months 7/1 212-32-5430 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If len Z7 is marked other than "natural" or items 22s and any injury or other traumatic 10c. City, Town or Location 10a State 1 ☐ Yes 2 🛣 No Hampstead Director Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21074 175 Weaver Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Sheetmetal Worker Union Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Alice Cole John Russell Geiman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 175 Weaver Lane, Hampstead, MD. 21074 Myra G. Geiman - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State ant Church Cemetery 11/23/09 Greenmount 22. Name and Address of Facility Eckhardt Funeral Chapel P Greenmount, MD Greenmount Church Cemetery 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD. 21117 . Ands Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner mesentanc 1schemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed discose Autonal and the burial-tran Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 No the 9 Unknown nas been signed by the 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 D N 2 No certificate 1 □Yes : After this certification and funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1972792505 anus MD 11/23/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Greene St James 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2\,\overline{0}\,\overline{0}\,\overline{9}$ 37802 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27, 2009 November 11:43 PM Doris Μ. Gotcher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore **Gilchrist** Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, April 2 5. Social Security Numbe 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Director Maryland <u> 15-34-1016</u> Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 🗆 Yes 2 💢 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 1603 Providence Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 ▼ Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Director of Lay Counseling Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sisson Lula B. Grueninger Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 1603 Providence Road Baltimore, Maryland John E. Gotcher injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-5-2009 Moreland Mem. Park Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tanrea disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 been signed by the should be detached g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an • Hospital or Attending Physician: The I 24 hours after death.
• Funeral Director: After this certificate h performed 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sicertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 6810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bushmi 70 harles

DHMH 17 Rev 7/2009

State Registrar

Box 68760

Records,

**Division of Vital** 

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 26, 2009 Marie I. Henderson 11:00 a M November 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Atlantic General Hospital Worcester Berlin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Month, Day, Sept. 21 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🖾 F 218-16-1229 84 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Maryland Baltimore Catonsville 1 ☐ Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Fairview Avenue 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grover Giddings Anna (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Roemer/ Daughter 41 Seafarer Lane Berlin, Maryland 21811 Date 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemeterv Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Euneral Service Licensee 301 Frederick Road Catonsville, Maryland 21228 Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse uence of): Uninor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed シェの タ/メン//۶スタ つゅう ハ/ユレ/クタ ブクラ 기/ Division of Vital Records, P.O. Box 68760<sub>25</sub> ed by the detached s been signed the should be detailed

Henderson

Marie

Physician/Medical þ Completed Be Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a live to Experiment to notified at one.

**Physician** /Medical

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certific

29a. Certifier

(Check only one)

0064120

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Berlin 21811. AaH 9733 Healthway Drive Zeeshan

State Registrar

Medical

and manner stated

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37804 = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Francis November 2009 9:25 am<sup>M</sup> Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Middle River

If Under 1 Year | If Under 24 Hrs. 119 Dihedral Drive Baltimore Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year 06/02/194 1**X** M 2 □ F Director 212 40 3916 66 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No |Maryland | Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Dihedral Drive 21220 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clyde Harris Elizabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Harris (wife) 119 Dihedral Drive Middle River Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 Burial 2 X Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory LLC 11/26/2009 Glen Burnie Maryland 21. S civiture o Fun, ral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final On et and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar . Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 37805 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:20 P David James Hare 22, 2009 /Medical Nov. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5751 Mineral Avenue Halethorpe Baltimore 8. Date of Birth (Month, Day, Year) 10-15-1940 6. Sex 1X M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 69 Massachusetts Director 213-36-3923 Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Halethorpe 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 5751 Mineral Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No1957 -If Yes, Give Year or Dates: 1963 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 XNo Specify: white ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 photographer own business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James F. Hare Margaret Brennan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Blob Hare 5751 Mineral Ave. Halethorpe MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 11-25-2009 Elkridge MD 21. Suratur of Funeral Service Lin 22. Name and Address of Facility Amurose Funeral Tome 1328 Sulphur Spring Road Arbutus MD 21227 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one come on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Mesothelioma Immediate Cause (Final en for **Physician** Mouths disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Day to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, 25 Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir

HXI

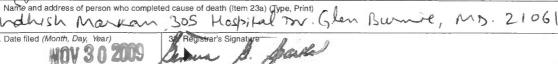
State Registrar

dhish Markan 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

(Check only one)



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D39505

29d. Date signed (Month, Day, Year)

November 23, 2009

09-09117	
Kimberly Hummel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State Ce	rtificate of	Death		,,,	Reg.	No. 200	9 3/80
Physicia	n/	Decedent's Name (First, Middle,Last)	77 7				e of Death oth Di ember 2:	ay Year	3. Time of Death 1601 hrs
Medical Examir		Kimber1y  4a. Facility Name (if not institution, give street and number)	Hummel	b. City, Town, or	Location of		ember 2	3, 2009 4c. County of Death	
		7818 Collingham Drive #F		Dundalk				Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea		Min.		MM/DD/YYYY) 9. Birti Foreigi	n New
Director		136-82-4527 1 M 2XF 25	Yrs.			M	arch 2	28,1984 Col	Jersey
any	+	Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Location	n					10d. Inside City Limits
7 8.4	٦	Maryland Baltimore		Dun	da1k				1 Yes 2 X No
ith the Maryland  23a or 28a-f show notified at once.		10e. Street and Number		10f. Zip Code		1222	10g.	Citizen of What Coun United St	•
hours after death with the Maryland inatural, or items 23a or 28a-f she Examiner must be notified at once		215 Detroit Avenue  11. Marital Status   12. Was Decedent Ever in U	IS 13 Was	Decedent of His			es or No-		can Indian, Black,
leath w	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		es, specify Cubar				White, etc.	
after d	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:		Yes 2 X No				Specify:	White
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		's Usual Occupa est of working life			one 11	6b. Kind of Business/I	ndustry
0036 within 72 jene. ner than "	Completed	12 Years 2 Years	De	ntal As	sista	nt		Dentist	Office
5-0( iled wi Hygiel fother the M		17. Father's Name (First, Middle, Last)						den Surname)	
21215-0036 Mental Hygiene. marked other than "natural", or ite	To Be	Richard Stephen Hummel  19a. Informant's Name/Relationship (Type, Print) (Mother	19b. Mailing	Address (Stre		garet A		r, City or Town, State	, Zip Code)
AD 2 sho 1 and 27 is mati		Mrs. Margaret A. Hummel					ndalk,	Maryland	21222
ore, Mes I and 2 of Health	1	20a. Method of Disposition 20b  1 XBurial 2 Cremation 3 Removal from State	. Place of Disposi crematory or oth		emetery,	Date	i	20c. Location - City or	
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: Oa	k Lawn C			11/28			e, Maryland
Baltimo permit. Page Department Important: injury or ott		21. Signature of Funeral Source Licensee	Dud	ame and Addres a-Ruck	s of Facility Funer	al Home	e of D	undalk, In	1C.
Physician		23a. Part I. Enter the disease, or complications that caused the deat	th. Do not enter the	22 Wise ie mode of dying	, such as ca	DUNG: ardiac or respi	ratory arrest	aryland 21 , shock, or heart	Approximate Interval Between Onset and
/Medical :aminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Sepsis							Death
.diffillor		or condition resulting in death)  Due to (or as a consequence  Pediococcus		)n					
	je	if any, leading to immediate Due to (or as a consequence							
\ U	Examiner	Couse. Enter this density of Couse (Disease or injury that initiated events resulting in death) Last	of):	<u>.</u>					
xecuted 4 (		d							
	Medical		ie a-b, 2	27, per	ME g9	00 2/5	/10 T		
8760, tificate be ng physic as the buri	- 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pre		tal death 3	Ectopic	pregnancy		23d. Date of deliver	y Day <b>Y</b> ear
Box 687 death certific the attending 1	sician	1 Yes 2 No 9 ✓ Unknown g Unknown	dooth	ner (Specify)					
hed the	Phy	Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause	given in Pa	art I. 2	23e. Did toba	acco use contribute to	the cause of death?
, P.O.	d b						1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
ords, P w requires t as been sign should be o	olete						24a. Was an autopsy	prior to	atopsy findings available completion of cause of
Recc The lav cate ha	Completed					1	perform ✓ Yes 2		es 2 No
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical examiner?   Hospital: 1   Innation: 2			e of Death	(Check only o		esidence 6 🗸 Othe	w Coope
n of Viding Physical  After this funeral di	P.	1 ✓ Yes 2 No This injuries 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of I		ury at Work	Nursing Hon 28d.		w injury occurred	1. Scene
ion c tending eath. tor: Af the fun	tion	1 X Natural 5 Pending (Month, Day, Year)		1	Yes 2	No			
Division of Vital Records, bostital or Attending Physician: The law require hours after death.  Ineral Director: After this certificate has been siy filled in by the funeral director, page 2 should b.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, stree	et, factory, office	building, et		Location (Str or Town, Sta		ural Route Number, City
Ospital ospital hours a uneral l	Š	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowle	adaa daath aanu	ered at the time	data and ni	ace and due t	o the cause	(c) and manner as sta	ted.
To the Howithin 24 Partner Function	edical	(Check only one) 2 Medical Examiner: On the basis of examination	and/or investigation	tion, in my opinio	on, death oc	curred at the	time, date ar	nd place, and due to the	ne cause(s)
Te wir	Me	and manner stated.  29b. Signature and title of certifier			nse number			29d. Date signed (Mo	
		MIN	m	0.0	.M.E.			November 24, 2	009
Ø		30. Name and address of person who completed cause of death (Ite Russell Alexander MD. Assistant Medical Exa		Penn Stree	t, Baltimo	ore, MD 21	201		
•	ate	31. Date filed (Month, Dav, Year) 32. Registrar's Signal	ature						
Regis		MAY 3 0 2009 Beneva B.	barke						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 6: JZ AM Leslie Harnecknie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral New York 1 🗆 M 2 🔀 F 0772571945 215-44-5651 64 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified MD Prince Georges Glenn Dale 1 Yes 2 □ No 10g. Citizen of What Country? 12127 Northbrook Drive 10f. Zip Code 20769 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Surname) Warren Taylor 19a. Informant's Name/Relationship (Type, Print) lb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6911 Alex Ct.m Frederick, MD 21703 Joseph Cramutola/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Chemation Services 11/24/2009 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State | Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Sovice Incensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atten for u in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year the the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, RENAL 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed CHRONIC DISFASF 1 ☐ Yes 2 ☐ No OBS TRUCTIVE Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 **N**0 မ 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Y Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier NOWEMBER 19 2009 D5 75

Registrar

DHMH 17 Rev 7/2009

State

Veterans Hwy

Sunte 204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601

82. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND A Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeanette Catherine Harvey 10:35 PM NOV 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospita Agres Baltironore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26, 1953 . Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD Funeral 1 □ M 2 □ XF 56 Months Days Hours Min. 217-56-4760 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, Ite Madical Evanthariants is not be netitied at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 ☐ Yes 2 X No Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 29 Turk Garth 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian 1 Tes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edison Mauldin Laura Berry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon E. Harvey (Husband) 29 Turk Garth Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 11/28/09 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fire of Funeral Service Licensee 22. Name and Address of Facility L. Kaufman Washington Funeral Home at MMP, Inc. Blvd. Elkridge, MD, 21075 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cau. (Final disease or condition resulting in death) the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ nevoic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Ye certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number P2H057 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier madical 11/22/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CODA DAMERA, 900 CONON AVE, BOIL: 1000E, MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JEANE

LARDAEN,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#9perFH, G900, 2/22/2010, WS
State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:28 рм Morris B. Hawley 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 7531 Harmans Rd. Harmans Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 7/3/1961 1 🛛 M 2 🗆 F Months Days Hours Min. Country) 082-44-9141 **Director** 48 NY Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Harmans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7531 Harmans Road 21077 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No White 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. Item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Branch Manager Pest Control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Morris Hawley Grace Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Hawley, Spouse 7531 Harmans Road, Harmans, MD 21077 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If Ite
any injury or ot Page 1 St. Patrick Cemetery 11/28/2009 Colton, New York 4 Donation 5 Qther (Specify) 22. Name and Address of Facility Buck Funeral Home, Inc. T. Harman 21. Signature 62 Riverside Drive, Colton, NY 13625 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the gode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 12000 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy perform Yes 2 prior to completion of cause of 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ၉ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death page and the time. Medical 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) en 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11,30 M Hairston Claudine DeWilda Bush Medical 4a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** si hai t Baltimore pited 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. (Month, Day, Year) Country) Director 300-12-5821 04 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Baltimore 1X Yes 2 □ No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21244 Tallow Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 and 2 should be filed within 72 hours after If Yes, Give 1 Yes 2 No Specify: Specify: Completed 3 🗆 Widowed 4 😾 Divorced Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Dept. of Health f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Human Services <u> Women Coordinate</u> 2th grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Hazel S. Bush Clarence V. Bush injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4803 Olney Road, Baltimore, Md 21215 <u>Wendell D. Hairston Sr.</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important; If ite 1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State cemetery, crematory or other place Donation 5 Other (Specify) Park 11/30/09 Woodlawn, Md Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Baltimore, Md 21215 Approximate Interval Between Onset and Death 2 day Physiciani disease or condition resulting in death) Medical Due to (or as | consequence of) **Examiner** Spirate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Vanc Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy After this certificate funeral director, pag 2 40 1 Yes 2 WHO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 2 No ၉ 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Director; / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined thin 24 hours after the Funeral Dire mpleted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and the of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of M	aryland /		rtment of F			ental Hy			27	011
		Registrar  1. Decedent's Nan	ne (First, Middle, La	st)		Cer	uncale or	Deau		2. Date of De		2009	3. Time o	Q I I
Phys		Sim	Hutchi	,						Month	Day	Year 2004	3. Time o	
- A	dical niner	4a. Facility Name		e street and number)	)		4b. City, Town, o	r Location	n of Death	- 11	4c.	County of Death	111	•
1		UMM					Bat	timo	52			,		
Funer		5. Social Security		ex 7. Ag ☐ M 2 🔀 F	ge (In yrs. last b	- "	If Under 1 Year Months Days	If Unde	er 24 Hrs.	8. Date of Bi (Month, D	rth av. Year)	9. Birth	place (State ntry)	or Foreign
Direct	or	220-22-9 Usual Residence of	9130	L W ZX	97	Yrs.				02 0		2	DC	
/land	5	10a. State	10b. County		10c. City, Tov	vn or Loc	ation						10d. Inside C	City Limits
Mary a-f sh	ţ	MD	NA		Bal	- i mo	vro.							2 No
th the or 28	Director	10e. Street and Nu			Dar	LIMO	10f. Zip Code				10g. Citi	izen of What Cou	ntry?	
ath wii 23a ust b	ral	1600 M	t. Royal	. Ave Apt	: 1010		2	1217	7			U.S.A	•	
and 21215-0036  be filed within 72 hours after death with the Maryland and Hygiene. In the Maryland of other than "natural", or items 23a or 28a-f show event, the Madical Exeminant the notified at	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. W	las Decedent of H Yes, specify Cuba	lispanic C an. Mexic	Origin? (Spec	cify Yes or No	)-	14. Race - Ameri Black, White,		
36 rs afte	by F	1 ☐ Never Marr 3 ☑ Widowed	ried 2 Married	1 □ Yes 2 <b>X</b> □ If Yes, Give	No		□Yes XIXNo	Specif		,		Specify: B1		
2 hours	pe	3K widowed	15. Decedent's Ed	Year or Dates:	16:	Decede	ent's Usual Occup	ation			16h Vi			
215 hin 72 an "na	Completed	(Spec	cify only highest gra	de completed)		(Give k	ind of work done of NOT use retired	during mo d)	ost of working	g	TOD. KI	nd of Business/Ir	dustry	
d 212 filed with Hygiene. ther than	l E	12th gi	rade	College (1-4or 5	Me	edic	al Reco	ord	Dept.	•	Har	lem Ho	spita	1
nd be file tal Hy d oth	Be (	17. Father's Name	(First, Middle, Last)					18. Mot	her's Name	First, Middle	, Maiden	Surname)		
arylan should be and Mental s marked o	ပု	Joseph							a Bol					
Maryland 212: 12 should be filed within th and Mental Hyglene. 7 is marked other than traumatic event, Ita. M.			ame/Relationship (7		191	b. Mailing	Address (Street	and Num	ber or Rural	Route Numb	er, City o	r Town, State, Zi	Code) 2	1217
or Health item 27 i		20a. Method of Dis	et Klain	-Sister			Mt. Ro							, Md
		ND Burial 2	□ Cremation 3 □	Removal from State	cemete		ition (Name of atory or other plac	i .	Da			cation - City or To	•	
Baltimo permit. Pages Department of Important: If i	nă l	-	5 ☐ Other (Specify yneral Service License		St.		omas Name and Addres		11/30	0/09	Ran	dallst	own,	Md
Balt permit. Depart Import	OUCE		1. W	1000	2	Ma	rch F/H	H We	st					
		23a. Part 1. Enter t	he disease, or comp	lications that caused	the death. Do	not enter	00 Waba the mode of dyin	asn ig, such a	AVE /	respiratory a	Lmor rrest.	e, Md	Approximat	te
Physicial		Immediate Cause	(Final	ine cause on each iir	ie.						,		Interval Ber Onset and	tween
/Medica		disease or condition resulting in death)	on 🕜		a consequence		cerebro	vesc	ile d	SARE				<u></u> _
Examine		Sequentially list cor	- distant		in arter		esse.							
ed sit	ine	cause. Enter Unde Cause (Disease or that initiated events	inditions,	Due to (or as	a consequence	of):	- 1 1 1 A				-			
executed n and al-transit	xam	that initiated events resulting in death) [	injury ast	c. Styperter	STON a consequence	-0								
cate be executed physician and the burial-transit	edical Examiner			Due to (or as a	a consequence	OI):								
<b>(2)</b> ∈ ¬ ⊗	edic			d										
Records, P.O. Box 6  The law requires that the death certif te hat been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregnancy						9	23d. Date of deliv	an/	
deatle atte	icia	in the past 12 1 ☐ Yes 2	months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other <i>(specify)</i>	/			1	Month Month	,	Year
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IS, Fires that signed to be detailed	by F	Part II. Other signif	1 1	entributing to death bu	it not resulting ii	n the und	erlying cause give	n in Part	I.	23e. Did to	obacco us	se contribute to the	e cause of o	leath?
cord w requir	ted	Myocare	TIAL INTE	Notion						10	∕es 2[	□ No 3 □ Prot	ably 4 🕮 l	Jnknown
Rec e law has b e 2 st	Completed									24a. Was		24b. Were auto	psy findings npletion of c	available
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Vita siciar certif	Be	25. Was case referr examiner?		Hospital:			104		e of Death (	Check only o	ne)			
Of Phys	5.	1 ☐ Yes 2 🖼	140	1 Inpatie	nt 2 ER/Ou	Itpatient		4 LI N				□Other (Specif	v)	
c g effe	Certification:	1 Matural 2 ☐ Accident	5 Pending investigation	(Month, Day	(Year)	njury	28c. Injury Work' M 1 □ Y	rat ? ∕es 2.⊑		d. Describe h	iow injury	occurred		
Visio	ifica	3 ☐ Suicide	6 Could not be determined	28e. Place of Inju	ry - At home, fa	rm, street		65 2 [		f. Location 75	Street and	Number or Rura	I Bouta Num	phor
Div	Sert	4  Homicide	determined	building, etc	. (Specify)		, , , , , , , , , , , , , , , , , , , ,			City or Tou	n, State)	rramber of riale	i i ioole ivalli	Dei,
ospit hour unera		29a. Certifier	1 Certifying Phy	sician: To the best of	f my knowledge	e, death o	occurred at the tim	ne, date a	and place, an	d due to the	cause(s)	and manner as s	tated.	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director;	Medical	(Check only опе)	∠∟ wedical Exami										the cause(s	)
Marie Marie	Σ	29b. Signature and t	title of certifier				29c. License	number			29d. Date	signed (Month,	Day, Year)	
			7-1	_ D.O	<b>)</b> -		148	7 8	8982	20	11/	22/09		
			ess of person who co	ompleted cause of de	eath (Item 23a)	Type, Pri	int)		1,		1	/		
-0.		31. Date filed (Monti	h Day Year)	32 Pagistra	77 Sou	th C	creene s	+ 15,	altimon	e MD	212	0		
Regis	ate rar	S. Date med (MONT	RIALL A A	oz. Hegistra	a Signature		29c. License 148 int) Freery S							
negis							- 61 M							I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Maryland / De State Registrar	partment of Health and M ertificate of Death	ental Hygiene Reg. No. 20 (	09 37812			
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Catherine Power Horton		2. Date of Death	3. Time of Death 4:45 A M			
	Examin	er	4a. Facility Name (if not institution, give street and number) College Manor	4b. City, Town, or Location of Death Lutherville	Baltimore				
	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Days Hours Min.	8. Date of Birth November 7,1919	9. Birthplace (State or Foreign Country) Maryland			
	/aryland 8a-f show tified at	ö	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  Maryland Baltimore Lutherv			10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	with the N 23a or 2 ust be no	I — I	10e. Street and Number 300 W. Seminary Ave.	10f. Zip Code 21093	10g. Citizen of Wh				
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2 be notified at other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2☒ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F     □ Yes 2 ▼ No Specify:	V4- \	- American Indian, , White, etc. white			
21215-0036	within 72 hou giene. <b>er than "nati</b> t <b>the Medica</b>	Completed by	(Specify only highest grade completed) (Gi Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired) Omemaker		home			
/land	d be filed valued by the desired of the desired of the life event,		17. Father's Name <i>(First, Middle, Last)</i> Robert Edmund Power	18. Mother's Name Stella	(First, Middle, Maiden Surname) Barbara				
Baltimore, Maryland	nd 2 should ealth and N n 27 is ma		Robert Thompson/grandson 5006	ulling Address (Street and Number or Rural Tulip Ave. Halet	Route Number, City or Town, Sta horpe, MD 2122	' ' '			
imore	Page nent c ant: If ury or		1 XX Burial 2 Cremation 3 Removal from State cemetery, o	position (Name of rematory or other place) Valley Mem GardNov. 2		ity or Town, State im, Maryland			
Balt	permit. Departr Imports any inju	1 10	21. Signature of Funeral Service Licensee  John Mutchell  23a Part 1. Enter the disease, or complications that caused the death. Do not one of the service of the service Licensee.	22 Name and Address of Facility, Fu 00 E. Padonia Rd.		of Dulaney Valle 21093 P.A			
09	death certificate be executed  x x x x x x x x x x x x x x x x x x x	edical Examiner	Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			Approximate Interval Between Onset and Death			
. Box 687		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	B   Ectopic pregnancy  Other (specify)	23d. Date Mont	of delivery th Day Year			
ords, P.O.	requires that t been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Demants a  Polician ced a se a			oute to the cause of death?  B Probably 4 Unknown  ere autopsy findings available			
l Reco	The law ate has page 2	Completed	25. Was case referred to medical		autopsy pri de 1 Yes 2 No 1	ior to completion of cause of eath?			
Division of Vital Records,	ding Phy h. After this funeral c	Certificate: To Be	examiner?  1	of 28c. Injury at 2	ne 5 Residence 6 Other 8d. Describe how injury occurred	110000			
Divisi	Hospital or Atteno 24 hours after deat Funeral Director: sted filled in by the		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,			
)	To the Hospital within 24 hours To the Funeral I completed filled	Medical	29a. Certifier (Check conly one)  1 Certifying Physician: To the best of my knowledge, deal conly one)  1 Certifying Physician: To the best of my knowledge, deal conly one)  3 Certifying Nurse Practioner: To the best of my knowledge.	restigation, in my opinion, death occurred at e, death occurred at the time, date and place	the time, date and place, and due t e, and due to the cause(s) and man	to the cause(s) and manner stated. ner as stated.			
	N Wit		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Typ  31. Date filed (Month, Day, Year)  32. Registrar's Signature	29c. License number  02473 2	29d. Date signed (	(Month, Day, Year)			
			30. Name and address of person who completed cause of death (Item 23a) (Typ	2/ West 1	2d. Tours.	21204			
	Sta Registra	te ar	31. Date filed (Month, Day, Year) NOV 3 0 2009 32. Registrar's Signature	parkol					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37813 Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2009 **Physician** JULIE 1-11RDY NOL 1926 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE N/A UNIVERSITY OF MARYLAND MEDILAL CENTER 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 42 Yrs 250-59-2854 South Carolina Director 02 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual Presentations. 10c. City, Town or Location 10d. Inside City Limits 10a. State South 1 □Yes 2 No Funeral Director Florence County Timmonsville Carolina 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3732 South Hill Road 29161 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2 No Completed by Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Carolina Elementary/Secondary (0-12) College (1-4or 5+) Home Health Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Cribb Tedder Dean ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Dean T. Cribb (Mother) 3732 South Hill Road, Timmonsville, SC 29161 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sparrow Swamp Baptist
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/2009 Timmonsville, SC 21. Signature of Fundal Service Uransee

Martin D. Lawso MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Lawson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 DA75 /Medical Due to (or as a consequence of) Examiner IMMUNO SO PPRESSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Examiner 2 MONTHS. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit LUNG TRAGUSDLANT Due to (or as a consequence of): Box 68760. IYEAR BRONEHIOLITIS OBLIFERANG Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD NOV 28, 2009 1069161 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC 225. GREENE SIFEET BALTIMORE MI LEYR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 3 0 ZUUS

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ T3, 2009 7:56 Helen November Αм Η. Huggins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye January 10, 9. Birthplace (State or Foreign Country)
1918 Georgia Funeral 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🛛 F Hours 259-28-2210 Director 91 Usual Residence of Decedent 10b. County "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Maryland Montgomery Kensington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 9916 Hillridge Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1944 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than 1 any injury or other traumatic event the Manany injury or other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) President Real Estate Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Claude Hatcher Cleo Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Huggins / Daughter 9916 Hillridge Drive, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery 27, 2010 Arlington, Virginia Signature of Funeral Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home /Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached for Unknown Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? alioblastoma Multiforma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed BRUAST ADENOCARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 No 1 TYes 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 2 🗌 No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 9 To the Hospital Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature)and title of cer#fie of person who completed cause of death (Item 23e) (Type, Print)

AFFIL DO FACH 11119 Kocky III. X 1119 Rockville Pike # 916 Rockville, 4d 20852 DI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 5per INF, G898, 12/3709, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 23, 2009 Leo Joseph Hart, Jr. 6:03 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery General Hospital Olnev Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Months 1 € M 2 □ F Davs Hours Min. 82 November 29, 1926 Maryland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits Montgomery 1 ☐ Yes 2 ☑ No Maryland Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14606 Bauer Drive 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 x Married If Yes, Give Year or Dates: Korea 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) of Health 5+ Biologist 18. Mother's Name (First, Middle, Maiden Surname) Helen Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14606 Bauer Drive, Rockville, Maryland 20853 November 27, 20b. Place of Disposition (Name of Montgomery crematory or other place) 20c. Location - City or Town, State 2009 Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue M01498 Approximate Interval Between Onset and Death CONGESTICE HEART Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 🔲 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? RENA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Punpuna THROMB OCTTOPENIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

P.O. Box 68760, Division of Vital Records, **Physician** 

/Medical

10a State

Directo

Funeral

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Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Examinating and any injury or other traumatic event, Inc. Medical Examinating and any injury or other traumatic event, Inc. Medical Examinating and any injury or other traumatic event, Inc. Medical Examinations. altimore, Maryland 21215-0036 Completed 17. Father's Name (First, Middle, Last) Be ၉ Leo Joseph Hart, Sr. 19a. Informant's Name/Relationship (Type. Print) Nancy Murray Hart/Wife 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Beard Director: After this certificate has been signed by the attending physician and filled in by the functer director, page 2 should be detached for use as the burnal-transit Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ cate has been sig , page 2 should b Completed IMMUNE 25. Was case referred to medical Be 1 Tes 2 No Certification: To 27. Manner of Death 1 Natural
2 Accident 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 35 635 November 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) 18111 JLNEY, Prince JOSEDH KUBLAN 20872 31. Date filed (Month, Day, Year) 32. Registrar's Signatur, State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 0 9 State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2:30 PM Gertrud Hodgson 2009 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Derwood Sycamore House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Days Hours Germany 1 □ M 2 💢 F 579-66-0085 Director Dec. 86 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20016 Funeral 4725 Albemarle Street, N.W. United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event the N. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Dress Store 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Josef Berninger Anna-Margarethe Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Hodgson/Son 4725 Albemarle St., N.W., Washington, D.C. 20016 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 28, Montgomery crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Crematorium, Inc. Robert A. Pumphrey Funeral/Bethesda-Chevy 21. Signature of Funeral Service Licenses M00198 7557 Wisconsin Ave., Bethesda 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease Years disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Month Pregnant at time of death the a 1 ☐ Yes 2 12 9 ☐ Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vascular Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Atrial Fibrillation 24a, Was an To the Hospital or Attentions within 24 hours after death.

To the Funeral Director. After this certificate has a the Funeral Director. After this certificate has a the funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗓 No Hospital Other: စ္ 4 Nursing Home 5 Residence 6 Other (Specify) Group Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 MD17577 November 23, 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2150 Pennsylvania Avenue, NW, Washington, D.C. 20037 Robert L. Jayes, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 00 /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street Examiner If Under Birthplace (State or Foreign Gountry) s. fast birthday) Security Number **Funeral** Months Days 219-70-581 20.0 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at 1 res 2 No Director Maryland and 2 should be filed within 72 hours after death with the I ealth and Mental Hygiene. n 27 is marked other than "natural", or Items 23a or 28a· 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Greensprin Funeral 12 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Spečity. 100 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Alurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Chambertain Walk မ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tran aaron Walker Green 00 20c. Location - City or Town, State 20a. Method of Disposition f Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 4 □ Donation 5 □ Other (Specify) 21. Signature of Furjeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused they eath. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (o /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as and burial-trar or Attending Physician: The law requires that the death certificate be exer Due to (or as a Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pre nancy
1 ☐ Live birth 2 ☐ Fetal dead
4 ☐ Pregnant at time of dead 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 2 No 1 ☐ Yes 1 🗌 Yes After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending ours after death.

neral Director: Af
filled in by the fur 1 ☐Yes 2 ☐No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours To the Funeral knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. If the cause (s) and manner as stated at the time, date and place, and due to the cause(s) 29a. Certifier Certifying Physician: To the best of nly completely (Check only one) iner: On the basis of e anner state 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 2 1 1 Q 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/20/2009 JONUS **Physician** Month MARION LOIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY

5. Social Security Number | 6. Sex GENERA COLUMBIA HOWARd 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
02/25/194/ NORTH CAROLINA **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 KF 212-36-0122 68 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exonity of the traumatic event, the Medical Exonity of the factorial of the contract of 1 ☐Yes 2 No Director HOWARD Ellicott MARY AND 10e. Street and Number 10g. Citizen of What Country? 21043 U.S.A. 8328 KIDGELI GOVENER Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: BLACK 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE 12 MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SON CHERRY ARRINGTON 2 19a. Informant's Name/Relationship (Type. Pript) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 10 43 permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra SON Ellicott City, MARYLAND JONES 8328 GOVENER RIDGELY LN QUENTIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MEM. PK, CEME 30 2009 BALTIMORE, MARYLAND 22. Name and Address of Facility The DERRICK C. JONES FIH, P.A. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 4611 PARK HOTS. AUR., BALTIMORE, MARYLAND 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ NO P.0. signed by the NI 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 XYes 1 ☐ Yes 2 ☐ NO Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Hospital: 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury n 24 hours after death.

Reference of the filed in by the file death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Humera Mujahid D59556 20/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Humere Mujahid HCGH columbia mD. 32. Registrar Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medio				Louise Joy						Month Novemb	<u>er</u>	25 2	Year 2009	9:40 F	РМ
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death items ner m	Fun	11. Marital Status		12. Was Decede	ent Ever in U.	s.	13. Was Dec	edent of H	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-		- Americk, White,	can Indian,	
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2 hours "natur adical	Completed	(Spe		nt's Education est grade completed)	0.	16a. D	ecedent's U	sual Occup	ation during most of w	vorkina	16b.	Kind of Bu			
ithin 7 lene. r than	Com	Elementary/Seco	onday (0-12)	College (1-4	or 5+)	Ìit	e. DO NOT	use retired)	technic	5		hosp:	ital		
filed wal Hygi	Be	17. Father's Name (F		Last)					18. Mother's N	Name (First, Middle			)		
uld be I Ment narke natic e	입			m Peddicor	d, Sr.					ances Se					
I 2 sho lith and 27 is r r traun		19a. Informant's Na Tames R.		nip ( <i>lype, Print</i> ) · ./ husband					and Numberor ckle Ct.	Rural Route Numb Fred		or Town, St Ck, M			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 2	20a. Method of Disp	osition	3 Removal from S		Place of D	isposition (A crematory o	lame of	- 1	Date	20c.	Location -	City or To	own, State	
it. Pagi rtment rtant: njury c		4 Donation	5 Other (S	Specify)			ter's	Cemet	ery 12/			ibert		a, MD	
Depar Impo any ir		21. Signature of Fur	revice l	Var2	Oer					Hartzler H. Liber				1762	
		23a. Part 1. Enter the shock, or hear	he disease, or t failure. List o	complications that	sed the deat line.	h. Do not								Approximate Interval Between	en
Physician/ Medical		Immediate Cause (I disease or condition resulting in death)		d	qaibri			1 1	irrest					Onset and Deat	
Examiner		resulting in death)		1973	as a consequ										
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executed an and rial-transi	Examiner	Cause (Disease or i that initiated events resulting in death) L	3 .	c. Due to (or	:				_						
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rtificate ling phy e as th	Physician/Medical	IF FEMALE:		00- 14											
ath ce attend I for us	ician	23b. Was decedent in the past 12 n 1  Yes 2	nonths?		th 2  Feta	al death	3  Ectop 5  Other		у			23d. Date Mor	e of deliv nth	ery Day Year	
t the de by the tached	Phys	g 🗌 Unknown		g 🗆 Unknov						-,-				_	
es that signed I be de	þ	Part II. Other signifi	icant condition	ons contributing to dea	th but not res	sulting in t	the underlyin	ig cause giv	en in Part I.					ne cause of death bably 4 🔀 Unkr	
v requii s been should	Completed									24a. Was		24b. W	Vere auto	psy findings availa	lable
The lav ate has page 2	Som,									— auto perfetti 1 ☐ Yes	ormed?	d d	rior to co leath? Yes	mpletion of cause	a of
ician: certific ector,	Be	25. Was case referre examiner?  1  Yes 2		Hospital:				Othe	ace of Death (C	heck only one)					
g Phys er this eral di	te: To	27. Manner of Death	1	28a. Date of		28b. Tim	ne of	DOA 28c. Injury	4 ∐ Nursing ⁄at	g Home 5 Resi 28d. Describe				2	
tending leath. cor: Aft the fun	Certificate:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendir Investi 6 ☐ Could	gation not be	Day, Year)	inju	M		Yes 2 No				_		
Il or At after of Direct		4  Homicide	determ	ined 28e, Place of	Injury - At ho , etc. <i>(Specif</i> y		, street, fact	ory, office		28f. Location ( City or To			r or Rurai	Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	☐ Medical E	Physician: To the bes examiner: On the basis Nurse Practioner: To	of examination	n and/or in	nvestigation,	in my opinic	on, death occurre	ed at the time, date	and plac	ce, and due	to the ca	use(s) and manner	r stated.
To the within To the comp	2	29b. Signature and t		1 11			2	9c. License	number			Date signed	(Month,	Day, Year)	
		30 Name and addre	Shoc ess of person	who completed cause	Dhysia			D00	16897	1	<del>-</del>	11/78	109	· ·	
81		Sho	aib Al	i	4	00 W	. Seve	enth S	St. F	rederick	М	D_217	01		
Stat Registra		31. Date filed (Month	NOV 3	0 2009 32. Re	strar's Signa	ture 1	bar	20			,				
							7	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #205266 Bemaryland? Department #205166 Bemaryland? Department #205166 09-09141 John Johnson 37820 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1826 hrs Medical Examiner November 24, 2009 hnson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Sinai Hospital Raltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min Director Country) 1 VM 2 215 Usual Residence of Decedent 10d. Inside City Limits Town or Location 10a. State 10c, Cit 1 Yes 2 No Himore hours after death with the Maryland Director 10g. Citizen of What Country Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes -Yes. Give Year 2 No 3 Widowed Δ Divorced Yes Specify d other than "natural", the Medical Examiner 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed uring most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) Be Umrson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m 2102 Cedar Circle Catonsville, Md. 21228 20c. Location - City o Town, State 20b. Place of Disposition (Name of cemeter best sate pleamorial 12/03/2009portant: If it γAnnapolis.MD. 2 - Cremation Removal from State Donation 5 Other Specify Nature of Funeral Ser Nat 23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of). Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be execute Physician/Medical 23a,27,perme, G898 12/10/09 TT XUNPENDED X AMENDED #5&19b, perFH, C897, 11/30/09, WS Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No ✓ Yes 2 No 1 Ves 26.Place of Death (Check only one) 25. Was case referred to medical

certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial director, Division of Vital Be this ۵ Certification:

examiner?

1 X Natural

2

Medical

1 🗸 Yes

27. Manner of Death

Accident

Laron Locke MD.

the Hospital or Attending Physician: neral Director: After t filled in by the funeral hours after death. the Funeral 24

Lo State Registra

28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie con

Pending

Investigation

28a. Date of Injury (Month, Day, Year)

29c. License number O.C.M.E.

Other:

28c. Injury at Work?

Yes 2

Nursing Home 5

29d. Date signed (Month, Day, Year) November 25, 2009

28f. Location (Street and Number or Rural Route Number, City

Residence 6

28d. Describe how injury occurred

or Town, State)

ne and address of person who completed cause of death (Item 23a)

Hospital:

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

28b. Time of Injury

Inpatient 2 V ER/Outpatient 3

31. Date filed (Month, Day, Year, Registrar's Signa 3 wa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death eygninei Day **Physician** 204 00 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Vorthwest GI tomorel If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🕩 F 74 Yrs. 217-34-994D Usual Residence of Decedent Director 6-20-1935 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liujuy or other traumatic event, I'm Modical Evaninar must be notified at any liujuy or other traumatic event, I'm Modical Evaninar must be notified at ange. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 AN Woodhwn **Funeral Director** MD Hallimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2120 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify If Yes, Give Year or Dates: Completed by Blace 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 100d Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman wood ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ave. Woodkarn, kub zi 207 te 20c. Location - City or Fown, State ones 6727 Kinc helde Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlam Cemelery 12-02-2009 Woodlan MS wayn c. Greene funeral S 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Randallstown, MB 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of trijury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 3 ☐ Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 DN6 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/□ER/Outpatient 3 □ DOA 1 Tes 2EMO 1 🔲 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ∏ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and le\_of certifier 12062650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 010 2010 all tour 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

37822

			For State Registrar	State of Ma	ryiand / L	Departme <i>Certifica</i>			тментан ту	rgien Reg. N		2 21066
	Dhysicia	an	1. Decedent's Name (First, Middle,	Last)					2. Date of De Month		ay Year	3. Time of Death
	Physicia /Medic		Evelyn C. Jac	ckson			Ţ	. La adiana di Ba	Novembe		-2 2cc	
4.	Examin	er	4a. Facility Name (If not institution, 1724) Since Kins BA 5. Social Security Number 6	VIEW MEDICA	L CENT	GR B	ALCI er 1 Year	MORE  If Under 24 H			c. County of De	rthplace (State or Foreign
	Funeral Director		204-24-2885 Usual Residence of Decedent	1 M 2 F F		Yrs. Months		Hours Mi	rs. 8. Date of Bi (Month, D		33	SC SC
	ryland how		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	he Ma 28a-f s	ecto	MD Balti	more		Pikes		le		100 (	Citizen of What C	1 Yes 2 No
	with t	i Dir	10e. Street and Number 4116 Ronis Ro	ad		101. 2	ip Code <b>2</b> ]	1208		Tog. C	U.S.	· ·
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examinations benefitied at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces?		13. Was Dec If Yes, sp 1 □ Yes		dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Am Black, Wh	
Maryland 21215-0036	be filed within 72 hou ital Hygiene. d other than "natura event, in Medial	Completed	15. Decedent's (Specify only highest	grade completed)		Decedent's Us (Give kind of w life. DO NOT	ual Occup ork done use retire	nation during most of w	vorking	16b.	Kind of Busines	s/Industry
212	d within giene.	Juo.	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+ 2vrs+	)	Nurs				Si	nai Ho	spital
pui	be filed valued be filed valued by the filed v	Be	17. Father's Name (First, Middle, La	*					<sub>lame (First, Middle</sub> e Aiken	e, Maide	en Surname)	
ryla	Mer Mer arke	은	Clinton Grant  19a. Informant's Name/Relationship		196	Mailing Addre	se (Straat		Rural Route Numi	her City	or Town State	Zin Code)
Ma	nd 2 suith ar 27 is r trau		Clarence Jack						Pikesv			
Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition  Burial 2 ☐ Cremation 3  Donation 5 ☐ Other (Spe	Removal from State		f Disposition (N ry, crematory or loodlaw			Date / 28/09		Location - City o	,
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Li	censee  K. Imea	7	March 4300	and Addre	ss of Facility H West ash Ave	e, balt	imo	re, Md	21215
	Physician		23a. Part1. Enter the disease, or construction shock, or heart failure. List or immediate Cause (Final disease or condition	nly one cause on each line	he death. Do	not enter the m	ode of dyi	ng, such as card				Approximate Interval Between Onset and Death 2 Nours
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	#						Iweek
√	cuted nd ransit	Examiner	Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a	19.7	on: LODNES	gión				8	month
68760,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	mphoi	*						Imonth
O. Box	requires that the death certific been signed by the attending p hould be detached for use as t	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome c 1  ☐ Live birth 2 4  ☐ Pregnant at 9  ☐ Unknown	! ☐ Fetal death	n 3 ☐ Ectopio 5 ☐ Other (		sy			23d. Date of d Month	elivery Day Year
rds, P.	w requires that s been signed b should be deta	d by Phy	Part II. Other significant condition	s contributing to death but	not resulting in	n the underlying	cause giv	en in Part I.			o use contribute 2 □ No 3 □	to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law ate has t page 2 s	Completed						-	24a. Wa — auto peri 1 ∐Yes	opsy formed	prior to death	autopsy findings available o completion of cause of
Vita	Physician; The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or:	Death (Check only			
on of	ding h. After funer	tion: To	1 ☐ Yes 2 No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending investiga	28a. Date of Injury (Month, Day,	/ 28b.	utpatient 3 🔲 I Time of Injury M	28c. Inju Wor	ry at	g Home 5 Res			pecify)
Divisi	I or Attending after death. Director: After I in by the fune	Certification:	2' Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28a Place of Injur	ry - At home, fa (Specify)		L		28f. Location City or To	(Street own, Sta	and Number or	Rural Route Number,
	Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best o kaminer: On the basis of and manner stat	examination ar	e, death occurr nd/or investigati	ed at the toon, in my	ime, date and pl opinion, death o	ace, and due to th ccurred at the time	e cause e, date a	e(s) and manner and place, and d	as stated. ue to the cause(s)
P	To the within 2 To the complete	Me	29b. Signature and title of certifier	1. 12		2		se number			Date signed (Mo.	
			1 June	M. 6 -			KES	s-000	)	No	vembe	12,2009
			30. Name and address of person w	ho completed cause of de		(Type, Print)	AJ	FARE	PAITH	MM	RE Mr	n 22, 2009 21224
4	Sta Registr		31. Date filed (Month, Day, Year)	32/Registra	's Signature	barke	P		D		-)''	-100

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21, 2009 NOVEMBER **Physician** ANNIE CECELIA JORDAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRINTON WOODS NURSING SYKESVILLE CARROLL & REHAB | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MARCH | 1, 7 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** 1 F 1927 MARYLAND 217-20-9998 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be written once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2 No Director MD CARROLL TANEYTOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 FAIRGROUND AVENUE 21787 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 ☐ Widowed 4 💆 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROY WARNER ADDIE HOOD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA JORDAN/DAUGHTER IN LAW 57 FAIRGROUND AVE., TANEYTOWN, MD. 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEMORIAL 11/28/09 BALTIMORE, MARYLAND 21. Signature of Funer Service Licensee Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that c used the death. shock, or heart failure. List only one cause in a ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or sels consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □Yes 2 No 2 <del>□ N</del>o funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Gratural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 22. Registrar's Signature NOV 3 0 2009

Nau, e and address of person-who completed cause of death (Item 23a) (Type, P/int)

Sur 100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37824 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** travella Jackson Nevembe 24 2009 loung /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kenhill Avenue 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral Days Months Hours Min. 1 □ M 2 🔀 F 215-30-0744 2 Director Mary land Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 No 2 No Director It imere Mary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 2122 ted Funeral HUZNU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sewing Elementary/Secondary (0-12) College (1-4or 5+) aberer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley dna Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore 20a. Method of Disposition Haywood - Nieca Dudley MO 21213 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Nov. 2 8, 200 Salem 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
CALUIN L. WILLIAMS
270 Fredhilten Pass 21. Signature of Funeral Service Licensee alvin 2. in Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Vimonan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 Hin 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ∕es 2∙Z No 1☐ Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 3□ DOA 1 Tes 2 ☐ ER/Outpatient ٥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturai 5 ☐ Pending investigation 1 🗌 Yes 2 □ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) DO 00

State Registrar VINE

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

60

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Months

10f. Zip Code

Rosedale

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

Days

21237

Rosedale

Min.

Koon

7. Age (In yrs. last birthday)

10c. City, Town or Location

Square Hospital Center

Way

Harris

1 □ M 2 😿 F

Baltimore

Ann

Month

8. Date of Birth

(Month, Day, Year)

07/07/1942

Year

Baltimore

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2X No

2009

4c. County of Death

10g. Citizen of What Country?

USA

2310PM

Physician/
Medical
Examiner

For State Registrar

BANKLIN Social Security Number

579-56-5568

Usual Residence of Decedent

10a. State

MD

10e. Street and Number

6634

Director

Rebecca

4a. Facility Name (if not institution, give street and number)

10h County

Kellv

**Funeral** Director

or 28a-f show notified at with the Maryland ıral", or items 23a or Examiner must be r death er than "natural", the Medical Exa

and Mental Hygiene. other traumatic event, Department of Health an Important: If item 27 is any injury or other training.

21215-0036

Maryland

Baltimore,

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota, Marshall shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. edema disease or condition resulting in death) cerebral Medical Due to (or as a consequence of) Examiner arresT rdiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by peen : this certificate has ours after death.

eral Director: After this certification in by the funeral director, illed in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending 2 🗌 No 1 Tes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 29a. Certifier сотріете (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia C Belair Rd 9524

Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Ashton Harris Gunter Foy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Koon / Husband Kelly Ann Way, Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Final Journey Crematory 11/26/2009 Woodbine, MD Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retween Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 □ No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Dajle signed (Month, Day, Year) 2000 ambliss MT 31. Date filed (Month, Day, Year) 32 Registrar's Signatur

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37826 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Ida Catherine Kane 10 Month BER Day 4 09:30M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Baltimore Towson Social Security Numbe 229-32-0498 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X 81 Director West Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the filed 275 is marked of other than "natural", or items 23a or 28a-f show ant. If item 275 is marked other than "natural", or items be notified at ury or other traumatic event, the Madical Examiner must be notified at 10b. County 10c. City, Town or Location Timonium 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2300 Dulaney Valley Road Apt. K-310 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jesse Williams Mabel Cottrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Tucker/Son 46 Jumpers Circle Baltimore Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 11/27/09 Covington Virginia 21. Signature of Puneral Service Licensel Leonard Jodr Ruck, Tacilinc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ BILATERAL PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Litter University Due to (or as a consequence of): Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death ☐ Pregnam
☐ Unknown the detached 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 after death.

Director: After this certificate ! 2 X No 25. Was case referred to medical examiner? director, Be 26, Place of Death (Check only one) 2 No Other: ဥ 1 Yes 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident iniury work? 5 Pending 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aft To the Funeral Dir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 4109 E D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE OSLER TOWSON, MARYLAND IM. М 7621

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Da

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009 Year 5:10 ам Levine Nov 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Arunde1 Crofton Rehabilitation Center Anne Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🎛 F 218-14-2813 Months Days Hours Min. ADTTT, Day WestryVirginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road 21114 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: White If Yes, Give 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses Hyman Bessie Margolis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Callas/Daughter 2715 Foster Avenue Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 27, Metro Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Pame and Address of Facility of Maryland, 9 Frederick Road Baltimore, Ĉrei 299 Alice Iser Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of a Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ☐ Pregnant Pregnant at time of death 

Other:

1 🗌 Yes

2 🗌 No

28c. Injury at

Ph\_sician/ Medical Examiner

Physician/

Medical

10a. State

Examiner

**Funeral** 

Director

show

or 28a-f

items 23a

ò

"natural",

and Mental Hygiene.

permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee.

event, the Medical

Examiner must be notified at

Director

Funeral

Completed by

Be

မ

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine or Attending Physician: The law requires that the death certificate be executed burial-transi and

attending physician for use as the signed by the a d be detached f page 2 should Jas this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

the Hospital

Physician/Medical ģ Completed Be မ Certificate: Medical

IF FEMALE: 23b. Was decedent pregnap in the past 12 month 9 Unknown

25. Was case referred to medical

29b. Signature and title of certifier

2 No

5 Pending

Investigation

determined

6 Could not be

examiner?
1 \sum Yes

27. Man er of Death

Natural

Suicide

4 Homicide

29a. Certifier

(Check

Accident

23e. Did tobacco use contribute to the cause of death?

20715

1 🗌 Yes 24a. Was an Yes 2 N 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of

1 Yes 26. Place of Death (Check only one) 5 Residence 6 Other (Specify, 28d. Describe how injury occurred

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year,

Bowie,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

14300 Gallant Fox Ln, #222 Rakesh Arora, M.D.

31. Date filed (Month, Day, Year)

32 egistrar's Signature

State Registrar 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year KENNETH L. LEDDICK 1105 Medical 009 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Center BalTimore Rosedale Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 6,1916 6. Sex XX M 2 D F 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Director 213-12-8697 93 Country) Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale Maryland 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 21237 9200 Oswald Way Apt. 2B USA items 2 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ò δ 1 Never Married 2 Married LeddにK Kenne Baltimore, Maryland 21215-0036 Specify: White If Yes, Give WW 11 Year or Dates. 1 ☐ Yes 2 No Specify: and Mental Hygiene. is marked other than "natural", Completed XX Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) vrs. Engineer Martin Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve ance. ပ Arthur Leddick Alberta Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. George R. Leddick (Son) 1863 County Rd. 4109 Campbell, Tx. 75422 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11-23-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fund al Service Licensee Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ruptured
Due to (or as a consequence of): Abdominal AOrTIC disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Pregnant
Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Compartment Syndrome 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

only one) 29b. Signature and title of certifier

Samyra

31. Date filed (Month, Day, Year)

9000 FRANKLIN

Registrar's Signature

RESODOO

DR

Balto md

Square

11-23-2009

lal

32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland, Department of Health and Mental Hygiene
Amend #2, per MD G900 2/3/10 CTT Certificate of Death

Reg. No. 200 Reg. No. 2009 Day 22 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician Ma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Te wn. or Location of Death Examiner Baltimore OurHard Garden If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Alabama 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Days **Funeral** Hours Min Months 1 ☐ M 2 🚾 F 2 378-16-0998 Usual Residence of Decedent Yrs. Director 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director SALTEMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.5.A by Funeral 14. Race - American Indian rraf", or Items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 "natural", or Specify: SIRCK 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) than, Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other thar Sec reface 274 11XS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANNIE WAY . OWENGS MEUS, MO 2/117 permit. Pages 1 and 2 Department of Health a Important: If item 27 is MANGHTER -IN-LAN Lee 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔁 Burial 2 □ Cremation 3 □ Removal from State injury or Waxilmun MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Belliely D. CROMPPITE FLS 21. Signature of Funeral Service Licensee -BALTO, MD 21323 homen Edmond SON Are Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metas adenocarcinoma Physician /Medical Due to (or as a consequence of): Examiner miled Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 2 🗆 No 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No cate has been significant categories categor Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 2 No 2 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Medical Certification: To Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of D 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) level nd Baltimore MD Donna 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 30

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 10:42 PM November Susie P. Lewis 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/ACeh Balpmore Balhmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 🖵 F 453-52-9722 76 Oct. 8, 1933 Texas Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 √Yes 2 No N/A Baltimore |Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 2458 Shirley Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ▼No 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Assistant Public Schools 12th grade 18. Mother's Name (First, Middle, Maiden Surname)
Eva Bedman 17. Father's Name (First, Middle, Last) Turner Huston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \_ 21201 19a. Informant's Name/Relationship (Type. Print) 844 W. Saratoga Street Baltimore, Maryland Millicent Lewis/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 12/2/09 Mem.PK 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Laurel, Maryland 21. Signature uneral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home Baltimore, MD 21215 5240 Reisterstown Rd Varris 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lypearded Due to (or as a consequence of): Atherosclerone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran certificate has been signed by the rector, page 2 should be detached within 24 hours after death.

o the Funeral Director: After this certific completely filled in by the funeral director,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

**Funeral Director** 

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shamplingty or other traumatic event, the Medical Examinar must be notified and proce.

**Physician** /Medical

Examiner

Examine

Physician/Medical

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Completed

Be

Medical Certification: To

attent known as ; Susie

Baltimore, Maryland 21215-0036

death with the Marylan

within 2

• 0	> Redenly Proj
5	30. Name and address of person who con

29a, Certifier

29b. Signature and title of certifier

29c. License number P50693

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29d. Date signed (Month, Day, Year) November 26, 2009

apleted cause of death (Item 23a) (Type, Print) Sinai Hospital of Mp Alden G. Peoples,

31. Date filed (Month, Day, Year)



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0712 +M Physician Zie 2009 November Landon Virginia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilia Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda If Under 1 Year If Under 24 Hrs. N/A 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Selx 1 ☐ M 2 💢 F **Funeral** Months Days Hours 8,1924 Nov. 85 Director 218-14-5557 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 □Yes 2 No Director Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 2626 Yorkway Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 12 Years is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel P. Turner Frank W. Sraver ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2406 Eagle View Drive Bel Air, Maryland 21015 permit. Pages 1 and 2 Department of Health s Important: If item 27 is Gary R. Landon (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/2009 Baltimore, Maryland Oak Lawn Cemetery injury 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner granulo matosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a conseq ence of): Examiner requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical as for use 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. p 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner<sup>a</sup> Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2⊿No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

ShyansJen 31. Date filed (Month, Day, Year)-

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

4940 Eastern Avenue Baltimore, mD 21224 Registrar's Signature

RES-00

November 26, 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ David Marshall Leitch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Ctr. Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-72-0120 M 2 - F 51 05/16/11958 Maryland Director Usual Residence of Decedent ! should be filed within 72 nous and should be filed within 72 nous and hand Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show to improve the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 312 T4 Highland Drive 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give DHV/U LE/TQH. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Leitch Patricia Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Glastonbury Drive, Virginia Beach, VA 19a Informant's Name/Relationship (Type Print)
Lexy L. McDoweII/Daughter 23453 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Ardent Cremation Services 11/25/2009 1 🗌 Burial 2 🛚 Cremation 3 🗀 Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N. Hanover, 21076 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition - Medical resulting in death) Examiner Syndhome Sequentially list conditions, cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🔲 Yes 2 ၉ 1 🛂 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 27. Manner of De 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: donth, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day 5:00 AM 2009 Alelia Belle Lake 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Levindale Hebrew Geriatric Cen Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 154 22 8742 79 24 1929 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County XX es 2 □ No Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA 3104 Garrison Blvd 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Black ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary/ Typist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis Baker Delloth Washington 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Weatherford 241 Fairmount Ct Shrewsbury Pa. 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 12 1 2009 Owings Mills Md Garrison Forest 22. Name and Address of Facility Phillip A Weatherford FS PA 21. Signature of Funeral Service Licenses 2431 E Oliver St Baltimore Md 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pancreatic cancer 3 months Date of delivery Month Year Day

NOV, 20, 2009

MD-21215

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Md

**Funeral** 

Director

iral", or items 23a or 28a-f show Examiner must be notified at

"natural",

n and Mental F

Department of Health ar Important: If Item 27 is any injury or other trauonce.

Director

Funeral

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Completed

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2

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours at To the Funeral Completely filled i

Division or Vital Records, P.O. Box 68760,

	Due to (or as a consec	uence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consec	uence of):			
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consect	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ā No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 📉 No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 211 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ 0	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
	nysician: To the best of my kniner: On the basis of examin and manner stated.				s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	)	2	9c. License number	29d. Da	ate signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)



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09-08976

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hvoiene

2009 37834

illiam Latham, J		For State of Maryland / Department of Health and Mental  Certificate of Death	Reg.		55 5105
Physician		eqistrar Decedent's Name (First, Middle,Last)	2 Date of Death		3. Time of Death
ledical Examin	er.	William Latham Jr.	Month Da November 19	9, 2009	0647 hrs
	4	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Do	eath	4c. County of Death Baltimore Cou	
		6603 Parsons Avenue Pikesville  Social Security Number 16 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24	ILLes 19 Date of Birth/	MM/DD/YYYY) 9. Bir	
Funeral	- 1	Months Days Hours	Min.	Foreig	ountry) MD
Director		214-68-2554 X M 2 F 46 Yrs. Yrs.	12 14	62	MD
any		Journal Residence of Decedent   10c. City, Town or Location   10c. City   10			10d. Inside City Limits
) } "		MD NA Baltimore			1 XYes 2 No
Aaryland 28a-f show 1 at once.	Director	Oe. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
the Man or 2		6603 Parsons Ave 21215		U.S.A.	
death with the Maryland or items 23a or 28a-f sho	ᇹ	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin?	( Specify Yes or No- uerto Rican, etc.)	14. Race - Amei White, etc.	rican Indian, Black,
or ite	Funeral	Never Married 2 X No 1 Yes 2X No		Specify:	Black
s after ral",	≥ -	Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind)	d of work done	6b. Kind of Business	
136 hin 72 hours afte e. than "natural", edical Examiner	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	e retired)		
5-0036 led within 72 hours after tygiene. other than "natural", ,	亂.	12th grade na Chef		Resta	urant
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	91	17. Father's Name (First, Middle, Last)	Name (First, Middle, Ma	iden Surname)	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	ш L	William Latham Sr. Mary  19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number)	Handy	er. City or Town, Stat	e, Zip Code)
D 21 should I and Mer 7 is man	-1	1			1
and 2 fealth.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City o	r Town, State
Baltimore, MD 2121, permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic events,	1	1 X Burial 2 Cremation 3 Removal from State crematory or other place) Woodlawn	1/24/09	Woodlaw	n, Md
Itin	H	4 Donation 5 Other Specify:  21 Sign ture of Funeral Service Licensee  22. Name and Address of Facility March F/H Wes			
Dep Depri	1	YILA . / / / ILE 14300 Wahash A	ve, balti	imore, M	d 21215
Physician		23a. Part I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	diac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
/Medical xaminer	1	Immediate Cause (Final disease a. Acute ethanol intoxication			Deaut
	П	or condition resulting in death)  Due to (or as a consequence of):			
	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Cause. Enter Underlying Causs (Disease or injury that initiated  Due to (or as a consequence of):			
Tansit ansit	Ä	events resulting in death) Last Due to (or as a consequence or).			
60, tte be executed hysician and e burial - transit	Physician/Medical	$\square$ AMENDED 23a,27,28a-f,perME, g898 1.	2/17/09 TT		
760, cate be physici the buri	We	IF FEMALE: 23c. If yes, outcome of pregnancy	pregnancy	23d. Date of deliver	ery Day Year
Box 6876( e death certificate the attending phy ed for use as the b	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic p	regilaticy	, month	
Box death he atte	ysi	1 Yes 2 No 9 Unknown g Unknown			to the control of depath 0
	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			to the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the ras after death ral Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detach.			24a. Was a		autopsy findings available
ord w req as bee	Completed		autops	sy prior t	o completion of cause of ?
Rec The la	E O		1 <b>Y</b> Yes 2	2 No 1 🗸	Yes 2 No
tal	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other;		Residence 6 🗸 Ot	her: Scene
Physicanthis eral di	10	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d Describe h	now injury occurred	alaahal
on Con Conding of the fun	tion	1 Natural 5 Pending Ed 11/10/00 Ed 6:39 am 1 Yes 2 X	excessi	consumed vely	alconor
Visior or Attend after death Director:	fica	2 X Accident Investigation 3 Suicide 6 Could not be Could not be		Street and Number or tate) 6603 Pa	Rural Route Number, City
Div	Certification:	4 Homicide determined (Specify) residence	Pikesvi	11e, MD	
To the Hospita within 24 hours To the Funeral completely fille	cal (	29a. Certifier (Check only medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)	ce, and due to the caus turred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
To the To the compl	Medical	and manner stated.		29d. Date signed (	
	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.		November 19,	2009
		30. Name and address of person who completed cause of death (Item 23a)		<u></u>	<del></del>
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201	=	
S	tate	31. Date filed (Month, Day, Year)  NOV 3 0 2009  37. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 37835 Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** SHELDIN LARAY MYERS AM NOV 2069 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia **Howard County General Hospital** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 8.58 Director MD Feb.8, 1960 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location show if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD **Ellicott City** Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8862-B Town & Country Blvd. 21043 by Funeral 12. Was Decedent Ever in U.S. Armed Forces! 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Landscaping Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Department of Health and Mental Important: If item 27 Is marked of any Injury or other traumatic ev Shirley Mae Bacon ျှ Charles Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley Bacon Mother 8862-B Town & Country Blvd. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Nov 24, 2009 Ellicott City, Maryland Good Shepherd Cemetery 21. Signature of Funeral Se 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Inter the dis shock, or mart failur. Approximate Interval Between Onset and Death , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on such line. Immediate Cause (Final **Physician** SPPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FNEWMONIA Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed ACQUIRED IMMUNUDEFICIENCY Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. 1 Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ SEIZURE DISURDER 1 Yes 2 No 3 Probably 4 Unknown Completed HEPATITIS 24b. Were autopsy findings available prior to completion of cause of death? performed certificate ! ANEMIA 1 □ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 5 29c. License number 29d. Date signed (Month, Day, Year) D0043662 NOV 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Hospital WILLIAMBOYCE CO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>2</sup>29, 2009 Month **Physician** Bernadette Morgan November 4:45 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ridgeway Manor Nursing Home Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 212-01-1507 91 May 25, Director 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16 S. Beaumont Avenue 21228 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Railroad permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Heiderich James W. Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Schmitt 9 Eastport Court; Lutherville, MD 21093 Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/3/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lice 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EW MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIOVASCULAR DISAASE MANY YAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, HEMORAGE, HYPORTENSION. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Natural Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 29c. License number D2754 ROVEMBER 30,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERRY RD, SULTE 4A BALTIMORE MD 21227 31. Date filed (Month, Day, Year, State NOV 3 n 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G897, 11/30/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** INEMBER 25 Jear T-50P Elmo Ray Mason /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNOLE GIEN ANNE Heunde BACTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 11/18/1919) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 90 219-07-9628 Director VΔ Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show rer must be retified at Anne Arundel MD Edgewater Director 1 ☐ Yes 2 ☑ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Steward Apt. 223 21037 USA 87 Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examinance. 1 ☐ Never Married 2 ☐ Married MASOLI FAST 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Worker Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Mason Pearl Watkins Mason ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Loveys Daughter 3418 Spring Azure Ct., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/29/2009 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall ) outo Mausha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EDIMORIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) physiclan and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year signed by the all d be detached fo 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ icate has been si ; page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate spital or Attending Physician: Theorers after death.
Ineral Director: After this certificat
y filled in by the funeral director, ps 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEFC149 (Lovember 25 2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gleu Burnie mi) Hochital

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

30

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37838 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 26, 2009 **Physician** 11:12 PM. WILLIAM J. MESTER, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 12501 MANOR ROAD GLEN ARM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Set **Funeral** 1 X M 2 □ F Director 9/18/1910 MARYLAND 99 214-03-1660 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show and 2 should be filed within 72 hours after death with the Maryla teath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f shov her traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE GLEN ARM 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21057 12501 MANOR ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 ☐ Yes 2 ▼ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □Xo Specify: WHITE If Yes, Give à 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **FOREMAN** MACHINE SHOP YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY C. AYD EDWARD HENRY MESTER ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 l WILLIAM J. MESTER, JR./SON 12421 MANOR ROAD GLEN ARM, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or ot ST. JOHN THE EVANGELIST 12/1/2009 HYDES, MD 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHURCH CEMETERY ddress of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO2 17 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTER Physician /Medical Due to (or as a consequence of): Examiner sentially list or offices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 \sum Nursing Home Hospital: 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name of the dress of person who completed cause of death (Item 23 ). The, Print) 7505 OSLER DRIVE SUITE 212 TOWSON, MD FRANCES CARMODY MD SR 31. Date filed (Month, Day, Year) 32. Redistrai State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per FH C898 12/9/09 TT
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Joseph Mann 2009 9:15 A M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1613 Four Georges Ct. Apt. Al Dunda1k Baltimore Social Security Numbe 8. Date of Birth (Month, Day, Year, **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. Months 1 ₹ M 2 □ F Hours Country) Maryland Director 215-84-47 June 6,1962 Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1613 Four Georges Ct. Apt. Al 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examing once. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Manufacturing Year Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose M. Pivinski Robert L. Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4026 St. Augustine Lane Dundalk, Maryland 21222 Mrs. Rose Mann (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 CCremation 3 Removal from State Hilltop Service Corp. 11/30/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Fugeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Mucha 23a. Part 1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မြ 1 🔲 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after deam.
the Funeral Director: Aft 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State: Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 25, 2009 7:53 A M Physician/ Judy Ann McLanahan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Port Deposit 90 Adams Road 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months 0677071944 Maryland 212-42-3717 65 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland Examiner must be notified at Director Maryland | Cecil Port Deposit 1 🗌 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. or items 23a 21904 90 Adams Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2XXMarried Yes 277No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental I မ Dorothy Crawford Charles Baublitz permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 Adams Road, Port Deposit, Maryland 21904 Kenneth C. McLanahan (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State Glen Burnie, Maryland 11/26/2009 Atlantic Crematory 4 Donation 5 Other (Specify) o Funera Service Licensee 22. Name and Address of Facility Bruzdzinski Funer 1407 old Eastern Avenue, . Sig Funeral Home, P.A venue, Essex, Maryland 21221 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or on the control of the control 23a. F y one cause on each line Onset and Death Immedia. £ause (Final disease or condition Physician Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XXYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No Yes 2XXVI certificate director, 25. Was case referred to medica 26. Place of Death (Check only one) å examiner? Hospital: Other: XX No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) After this 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

s after death.

I Director: After this d in by the funeral di within 24 hours a

To the Funeral C

completed filled filled Hospital

Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and title of ce

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PHYSICIAN

ノイド 32. Registrar' Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Extrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0058475

ATUCOD ROAD

29d. Date signed (Month. Day, Year)

NOVEMBIEN 30 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year November 24,2001 4c. County of Death Elizabeth Porter Martin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death osedale baltimore Fran Glin 5. Social Security Number Square 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ige (In yrs. last birthday) If Unde If Under 24 Hrs Hours Min. Months Days 1 □ M 2 🕱 F Yrs 89 1/1/1920 Maryland 215-16-4941 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2X No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 304 Jeanwood Court S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify 2 Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Aero Space <u>Waitress</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Carletta Richardson Matthew Ellis Martin, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Jeanwood Court Dundalk, Maryland 21222 Modena Metz (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 27/25 4 □ Donation 5 □ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue nichael C. Jug PA Essex, Maryland 21221 Sr. pplical in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. Limited in the shock of the shock Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Depsi. Due to (or a a consequence of): Tract Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last eumonia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical **Examiner** and P.O. Box 68760 Records. **Division of Vital** after death. e Hospital o 24 hours aff e Funeral Di

Examiner Physician/Medical Completed Be Certification: cal

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ing Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ire Magany Injury or other traumatic event, Ire Magang

**Physician** 

with the Maryland

Baltimore, Maryland 2121

67

State

within 2 To the

29a. Certifier (Check only one)

29b. Signature a

Registrar

DHMH 17 Rev 1/200:

30. Name a address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MASTUADED, M.D

32. Registrar Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO064755

29d. Date signed (Month, Day, Year)

11/24/09

Franklin Square Drive, Baltimore, mb. 21237

November 24, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricía Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Yea 32. Registrar's Signature State Registrar **ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#31perDVR, G897, 11/30/09, Ws
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ilse Miller November 27,2005 Doris 2:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rossville Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Director 403 56 5400 May 26,1937 Germany Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 🗆 Yes 2 🔽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7215 Greenbank Road 21220 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment. Important: If item 27 is marked any injury or call. Edward Η. pe Haaq Marie Blum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde A. Miller (husband) 7215 Greenbank Road Baltimore Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cen 12/04/2009 Garrison Forest, Md. 21. Si ature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Baltimore, Md 21221 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GASTRUEINTESTINAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 🗍 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown ō that the death Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ABBTES MELLITUS Division of Vital Records, requires 4 Unknown Completed 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy CHRONIC OBSTRUCTIVE WAS DISTOSE perform death? certificate 2 No 1 Yes 25. Was case referred to medical Hospital or Attending Physician: director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X\(\)0 ပ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. ithin 24 hours after death.

the Funeral Director: Ai

mpleted filled in by the fu Accident М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29c. License number 2009

State

30. Name and address of person who completed caus

31. Date filed (Month, Day, Year)

Belair Rd, Batto., MD. 21236

death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2009 November 8:05 A M June Beatrice Moses /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Center-Genesis Eldercare Baltimore 8. Date of Birth (Month Day Year) 06/10/1922 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🔀 Months Hours Washington DC 87 219**-**14-2280 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Wedical Examiner rust be notified at MD Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21222 U.S.A. 321 Trappe Road Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 🗷 No Specify: <u>ک</u> If Yes, Give Year or Dates: 3 ☐ Widowed 4 🔯 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental F Be Doral Evelyn Wayland Leonard Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Trappe Road Baltimore, MD 21222 19a. Informant's Name/Relationship (Type. Print) s1 and 2 st of Health ar 3 Deborah Stachowiak/Daughter permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 11/30/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service licensee 1018 21076 7522 Connelley Drive, Ste.N, Hanover, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine death certificate be executed physician and s the burial-trans resulting in death) Last P.O. Box 68760 Physician/Medical ast attending IF FEMALE for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) the a ☐Yes 2☐No detached n signed by th' 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Onknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **D** No 1 □ Yes 2 12 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37845 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Sylvia Meed Mary GOOA M NOVEMBER 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🔀 F 109-18-9275 84 Director 1/4/1925 New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 U.S.A. 715 Maiden Choice Lane HV 510 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It a Manuary Injury or other traumatic event, It a Manuary Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simone Rose Ingraldi Anthony ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Meed/ Husband 715 Maiden Choice Lane HV 510, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 11/24/2009 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P., Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical the as attending use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 No the detached 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð FAILURE 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 1 ☐ Yes 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, of Vital Division

o

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law Certification: To completely filled in by the funeral 24 hours after deat Funeral Director; Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30989 NOVEMBER 21 2009 ted cause of death (Item 23a) (Type, Print) dress of person who comp 711 MAIDEN CHOICE LANE CATONSVILLE MD WIQ pubblication Registrar's Signature State 30 Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physician/ Month 3:05 A M Medical Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7. Age (In vrs. last birthday) if Under 1 Year I if Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Day Ob 61 Hours Country) Director or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Baltinore 1 Yes 2 🗌 No 10e. Street and Numbe 10g. Citizen of What Country? Elmira USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Saltimore, Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industr (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 2 Place of Disposition (Name of ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servi 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent the mode of dying, such as shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Dirato (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) og physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account at the time. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chines ST CHARLES

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Zact	hary Anthon		bus 1- For State Registrar	State of M	aryland		rtment of tificate of		and	Menta	al Hyg		eg. No.	20	<b>n</b> 9	3	784
	Physicia	an/	Decedent's Name (First,	Middle, Last)							2	. Date of Dea	th	Year		ime of Dea	
Med	dical Exami	ner			obus							Month November				204 hrs	
			4a. Facility Name (if not in: Chester River Ho		and numbe	r)	4	b. City, To Cheste		ocation of	Death		Ke	County of Dea nt	ith		
	Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under	24Hrs. Min.	8. Date of Bir	th(MM/DE	D/YYYY) 9. E Fore		ce (State c	r
	Director		136-96-1773	1 X M 2	F	1	9 Yrs.	MONUNS	Days	Hours	IVIIII.				) AL		
	è		Usual Residence of Deced			10c. City.	Town or Location	on							100	. Inside Ci	ty Limits
2	d how a	_	MD	Kent			Gale								1	Yes 2	X No
_	Maryland 28a-f show any d at once.	Director	10e. Street and Number					10f. Zip C	ode			1	0g. Citize	n of What Co	untry?		
	the M la or 2		223 Phelps	Avenue				216	535				Ur	nited S	Stai	tes	
_	h with sms 23	Funeral	11. Marital Status		as Deceder	nt Ever in U.		Decedent s, specify				cify Yes or No	- 14	4. Race - Am White, etc.		Indian, Bla	ck,
	er deat , or it	Fu	1 X Never Married 2  3 Widowed 4	Married 1 1 Divorced If Yes,	Yes	2X No		Yes 2				, , , , , ,		pecify:	Wh:	ito	
	urs aft tural" amine	ğ	3 Widowed 4 15. Decedent's Education	or Date	es:	mpleted)	16a. Decedent				nd of wo	rk done		nd of Busines			
	72 hor n "na	Completed	Elementary/Secondary		ollege (1-4 o		during mo	st of work	ng life. D	O NOT u	se retire	d)					
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	21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, M						18		•	First, Middle,					
	212 Auld be Menta mark	e e	Alan L. Mo	ationship (Type, Pr			19b. Mailing	Address	(Street a	Geor and Numb	aett er or Ru	ce Zimr	nerma nber, City	or Town, Sta	te, Zip	Code)	
	MD 2 sho atth and m 27 is aumati		Georgette El	lis, Mot	her		223	Phelp	s Av	venue		alena,	MD 2	21635			
	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  I friem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 X Cre	and the second	moval from S		Place of Disposi crematory or oth		of ceme	etery,		Date	20c. Lo	ocation - City	or Tow	n, State	
	Baltimore, permit. Pages I ar Department of He- important: If ite		4 Donation 5 Ot	ner Specify:		000	an County				12/	02/200	Ton	ns Riv	er,	NJ	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-5 sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral S	ervice Licensee	T. Ha	ırman		ame and A				dz Fune					
	Physician	1 (1)	23a. Part I. Enter the disea	se, or complication	s that cause	ed the death	. Do not enter th	∠3 ⊓C e mode of	opei dying, si	C AVE	nue diac or i	Toms respiratory an	R1VE	k, or heart	A	pproximate	
	/Medical	V S	failure. List only one Immediate Cause (Final di			e int	oxicati	oπ							Į E	Between Or Deaf	
(	xaminer		or condition resulting in de			sequence o											
		r	Sequentially list conditions if any, leading to immediate		(or as a con	sequence o	f):		_	_	_				-		
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	Box death he atte d for u	hysician/M	1 Yes 2 No 9	Unknown g	Unknown		5 Oti	ner (Speci	y)		2010						
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	ivision  or Attend after death Director:	ifica	2 Accident 3 Suicide 6 X	Could not be	Be. Place of	Injury - At h	ome, farm, stree	et, factory,	office bu	ilding, etc	. 2	28f. Location or Town, alena,	Street an	d Number or	Rural I	Route Num	ber, City
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_	£ 2 £ 8	Me	29b Signature and title of		State	/Y	BDAU	29c.	License	number			29d. D	ate signed (	Month,	Day, Year)	
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	$\phi$		30. Name and address of Victor Weedn MI			f death (Item al Examii		enn Str	eet, Ba	altimore	, MD 2	21201					
		ate	31. Date filed (Month, Day	Year)	32. Regist	raris Signati	arke										
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			For State Of IVI State Registrar	aryland / Depa <i>Cel</i>	rtificate of L		entai mygi Re	g. No. 2009	37848	
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	John Joseph McDonough, 3  4a. Facility Name (If not institution, give street and number,		4b. City, Town, or		November	27, 2009 4c. County of Death	4:00 A M	
	Examin	er	National Lutheran Home			ockville		Montgomery		
	Funeral		5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign untry)	
- 10	Director		003-14-0778 1\square M 2□ F	82 Yrs.	Months Days	Hours Min.	December 2	9. Birtl 28, 1926 New H	lampshire	
-	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryi Fisho	tor	Maryland Montgomery		Potom	ac			1 □ Yes 2 🙀 No	
	or 28a	Director	10e. Street and Number	1	10f. Zip Code		10	g. Citizen of What Co	untry?	
	23a c		12509 Stream Wood Lane		2	0854		United Sta	ites	
036	is 1 and 2 should be lifed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Mine Z1 is marked other than "natural", or items 23a or 28a-f show inter Z1 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is the circuit and the contract of th	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces 1 ▼ Yes 2 □ If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🛣 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	city Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: Whi	, etc.	
21215-0036	n /2 ho "natur edicel	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	ation furing most of working )	g 1	6b. Kind of Business/I Library of		
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pu	al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Surname)		
ylaı	Ments Ments arked atic e	2	John Joseph McDonou	igh, Sr.		Madrien	ne Cecil	ia McGuine	ess	
Maryland	2 sho		19a. Informant's Name/Relationship (Type. Print)	1				City or Town, State, Z		
é,	T and Health 9m 27 ther t	13	Dorothy M. McDonough/Wife  20a. Method of Disposition					ac, Marylar		
Baltimore,			1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State	TIOH CAOMEL	matory or other place	Novembe	r 30,	•		
iii i	permit. Pages Department of Important: If it any Injury or one		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses,	Crematori	liim. Inc.	:2009	rt A. Pi	ethesda, M umphrev Fu	aryland neral Home/	
B	any per	7 4	11111	M01498   R	Rockville, Rockville.	Inc. 300 Maryland	West M 20850	ontgomery	neral Home/ Avenue	
	hysician /Medical Examiner	0. 1	Due to (or as	d the death. Do not entine.  c Cerebral s a consequence of):  n Tumor	ter the mode of dying	g, such as cardiac or	r respiratory arre	st,	Approximate Interval Between Onset and Death	
68760, K	icate be executed physician and the burial-transit	ledical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):						
Division of Vital Records, P.O. Box 6		Physician/Me		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date of del Month	ivery Day Year	
JS, P	signed b	δ	Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?	
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Vital Records,	ate has	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of 2 No	
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of \	this o	၉	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpat	ient 2 ER/Outpatier		4 KM Nursing Horr		nce 6 ☐ Other (Spe	cify)	
on o	aing Fri h. After th funeral	tion	27. Manner of Death  1 ★Natural 5 Pending (Month, Death investigation)	ury 28b. Time o ay, Year) Injury	Work	yat ?? Yes 2 □ No	8d. Describe ho	w injury occurred		
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į	o thickir	Me	29b. Signature and tipe of certifier	A .	29c. License	e number	29	9d. Date signed (Mont	h, Day, Year)	
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			Suff MAN	mo	D00.	50612		November	27, 2009	
	5+1		30. Name and address of person who completed cause of Samuel George Maller, M.D.	death (Item 23a) (Type,	Print)		e, Maryl	November Land 20850	27, 2009	

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carl W. Messinger 2009 P<sup>M</sup> November 5:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1 Carvel Circle Montgomery Bethesda 3005e3013311 6. Sex 1 A M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Ye Country)
Connecticut Director 150-26-7986 1924 85 June Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c, City, Town or Location 1 ☐ Yes 2🌠 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 United States 1 Carvel Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: 3 XWidowed 4 Divorced WWII Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Speed O'Connor Carl Wordin Messinger, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256A Heritage Hills Drive, Somers, New York 10589 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Marianna M. Kuhn / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place 20, November 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 2009 Signature of Funeral Service Licenses R<sup>22. Name and Address of Facility</sup> Bert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 17557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 John Ston M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of Examiner End Stage Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Atherosclerotic Vascular Disease attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown plnous been 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 \square Yes 2 \square No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a hours Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 🗆 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) M November 17, 2009 DC16518 30. Name and add ss of per (ho completed cause of death (Item 23a) (Type, Print) not Guitecman, M.D. 2141 K St., NW #603, Washington, D.C. 20037-1810 Α. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of M		Cer	tificate of l	Death			Reg. N	ي 200	9 3785
	Physicia	ın/	1. Decedent's Name (First, Middle, La	est)						2. Date of Dea		av Vaar	3. Time of Death
	Medic	cal	Thomas Frede							November			6:53 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Chevy Chase								1 -	. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I if Under 24 Hrs. 8.								h	9. Bir	thplace (State or Foreign
	Director		_040-24-05//	1 XM 2 □ F	91	Yrs.	Months Days	Hours	J Min. J	(Month, Da anuary	20 <b>,</b> 1	918 Con	necticut
	ind show	٥ľ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits
	Maryla 18a-f s tified	Director	Maryland Montgo	mery	Che	vy Cha	ase						1 ☐ Yes 2 💢 No
	a or 2 be no	Ö	10e. Street and Number				10f. Zip Code				10g. C	itizen of What Co	ountry?
	th with ns 23 must	Funeral	3607 Cardiff Roa					815			Unit	ed Stat	es
<b>'</b> O	or iter	by Fu	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2</li></ul>	12. Was Decedent E Armed Forces? 1 A Yes 2	ver in U.S.	13. V	Was Decedent of H f Yes, specify Cuba	lispanic C an, Mexic	rigin? (Specit an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, White	
93	rsafte iral", Exan	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	WWII	_   1	I∐ Yes 2 🛣 No	Specif	fy:			Specify: Whi	te
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9	iled w I Hygi other	Be	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		1011	crear or		****	First, Middle,			
Maryland	12 should be filed value and Mental Hyg 27 is marked othe r traumatic event,	잍	David McCoy				_	Ar	na Fol	ley			
/an	shoul and l		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	ng Address (Street	and Num	ber or Rural F	Route Numbe	r, City o	r Town, State, Zij	o Code)
<b>≥</b> •	and 2 Health em 27 ther t		Kevin S. McCoy /	Son	Took Die		Brennon sition (Name of	Lane					
nor	age 1 ent of 1 trifit		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cen	netery, cren	natory or other plac	ce)	Nov. 2	29 <b>,</b>		ocation - City or	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer		Montg	-	Crematorium Name and Addre	-					Maryland
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jean N. McNelis 1:07  $P^{M}$ 2009 November 14. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adentist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 30, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 85 579-20-8861 Washington, D.C. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mast be rediffed at 1 NYes 2 □ No Director Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 407 Russell Avenue, United States #812 20877 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates; 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed vent of Health and Mental Hygirint: If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph C. Newman ပ္ Edna Kidwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 Barcellona Drive, Gaithersburg, Maryland 20879 Cynthia C. Merriam/Daughter permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other: once. Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 22, 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licen Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pulmonary Embolism minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 □Yes 2 □No 1 □ Yes 2 🔀 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 14,2009 40051791 amarci 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Tamara L. Kile, D.O.

31. Date filed (Month, Day,

32. Registrar's Signature

9901 Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23, 2009 Physician/ 2:00p M November Agnes Wanda Michalak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co Gilchrist Hospice Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. (Month, Day, Year) Mar vland 1 M 2X F Director 219-18-7156 84 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Der artment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at onne. 10b. County Director 1 ¥ Yes 2 □ No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21224 USA 822 South Robinson Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Specify White 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (UNK) Vincent Nowakowski Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19720 Middletown RD. Freeland, MD 21053 Kathleen Feeser - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State  $11 - 2^{Date} - 09$ 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Dundalk, MD Jėsus Cem. 22. Name and Address of Facility Kaczorowski Funeral 21. Signature of Funeral Service Licenses Robert Dundalk Avenue Baltimore, MD 21222 1201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mars disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 18 months?

1 Yes 2 No
9 Unknown Year Month Dav Pregnant at time of death a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital Other: 1 ☐ Yes 2 ☐XNo 4 Nursing Home 5 Residence 6 Oother (Specify) Will ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 2 Accident Natural 5 Pending 1 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie November 27 2009

State Registrar 670

and address of person who completed cause of death (Item 23a) (Type, Print)

w

32. Registrar's Signature

CHAZUES

31. Date filed (Month, Day, Year)

**OCME 2006** 

31. Date filed (Month, Day, Year) NOV 3 0 2009 Registra DHMH 17 Rev 1/2001

29b. Signature and title of certification

Jack Titus MD.

ORIGINAL

who completed cause of death (Item 23a)

Registrar's Signature

Deputy Chief Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

**OCME** 

29d. Date signed (Month, Day, Year)

November 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 20, Zvog 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NAOD TO THE DE 4,40 PM Nobles C. Linwood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14 undel Baltimore Washington Med. Center Burn If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**火** M 2 □ F Days Hours Day, Months Director 218-36-8247 NC 70 Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. Margate Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) United Airlines 12th\_grade Ramp Service na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Dollie Yates Joe Nobles Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 109 Margate Drive, Glen Burnie, Md 21061 Sarah Nobles-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/2/09 Owings Mills, Md Garrison Forest Vet 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Limer University Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown ed by the a detached f Records, P.O. ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The this certificate 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Suppatient 2 ER/Outpatient 3 DOA ပ Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred i Natural 2 Accident 5 Pending work? Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Vithin 24 hours are To the Funeral Dir Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

State Registrar 31, Date filed (Month, Day, Year)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ :45 p M 2009 Nov Purvis Joan Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10105 Clearspring Road Montgomery Damascus 9. Birthplace (State or Foreign Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** May 20, 1943 Hours Months Louisiana 1 🗆 M 2 😓 F 66 Director 253-64-7190 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limit 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Damascus Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a Examiner must b Funeral 10105 Clearspring Road 20872 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ballet Teacher Ballet School other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lee J. Cauvin Pauline Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward E. Purvis/ Husband 10105 Clearspring Road, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State November 24. Department of H Important: If its any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. Signature of Juneral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Caucer Priysician/ rjear tasta disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Saquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral ( 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending ✓ Natural hours after death. Investigation Accident Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completed fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8262 Suite 330 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 2401

MENDHIRATTA

32. Redistrar's Signature

31. Date filed (Month, Day, Year)

Research BLUD Rock

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

37857

		•	State Registrar	,	Certific	ate of L	Death	F	Reg. No.	
	Physicia		1. Decedent's Neme (First, Middle, Last)  Maring Parile	77				2. Date of Dea Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. C	City, Town, or	Location of Deat		4c. County of Dea	·
			Seasons Hospice				llstown		Baltimor	
	Funeral Director		011-00-2777	7. Age (In yrs. last	Yrs. If Ur Mont	ths Days	If Under 24 Hrs. Hours Min.	(Month, Day	y, Year)   C	rthplace (State or Foreign country) - Hh CAROLINA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
	Mary I-f sh	tor	MD.	B	BALTIN	IORE				1 Yes 2 □ No
	or 282	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·	10f.	. Zip Code			10g. Citizen of What C	ountry?
	23a c		2603 ROSEW	DOOD AVENU			1215		4.5.1	
36	be filed within 72 hours after death with the Maryland ntal Hygiene.  sd other than "natural", or Items 23a or 28a-f show event, the Medical Evarance must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1		ecedent of Hi specify Cuba s 2 No	ispanic Origin? (S in, Mexican, Pueri Specify:	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
5-0036	2 hou	ted	15. Decedent's Educ		6a. Decedent's I	Usual Occup	ation during most of wo	ekine	16b. Kind of Business	s/Industry
2121	ithin 7 ne. nan "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired	)	-	Home MA	Ker-
	filed withii Hygiene. other than ent, the		17. Father's Name (First, Middle, Last)		House	WIF		1	Maiden Surname)	
Maryland	be d c	Be C	ALBERT COI	2. 4/					NEAL	
Z.	should be f and Mental I s marked of aumatic eve	우	19a. Informant's Name/Relationship (Type	pe. Print)   1	19b. Mailing Add	ress (Street a				Zip Code) 21215
	4 E		CHARLES PARKER	SR. HUSBAND	2603	ROSE	WOOD A	LVE. BI	ALTIMORE	MARY AND
altimore,	80 C = =		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R	20b. Place	e of Disposition ( etery, crematory	(Name of or other plac	e) [2]	Date	20c. Location - City o	r Town, State
Ē	permit. Pages 1 Department of P Important: If ite any Injury or of		4 □ Donation 5 □ Other (Specify)	mt. C	ARMEL	Cemet	exy: 10	2/2009	BALTIMOR	E, MARY LAND ONES FIH, P. A DE MARVIAND Approximate
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service License	e	22. Nam	e and Addres	ss of Facility	E DERR	icle C. J.	DIES FIH, PIA
	σ□ = e O		The state of the s	- P	4611	WARI	K HG+S	. AVE.,	BALTIMORE	Approxi ate
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		-	-	c or respiratory ar	rest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen-		UITIO (	carry			
4	Examiner				ice oi).		-			
		ner	Sequentially list conditions, in any, leaving to initional cause. Enter Underlying	Due to (or se a consequen	ea of):					
X	icate be executed physician and the burial-transit	Examiner	that initiated events							
90,	be execian a		resulting in death) Last	Due to (or as a consequen-	ice of):					
68760,	physi the t	Medical	d							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗌 Ector	pic pregnanc er (s <i>pecify)</i>	у		23d. Date of d Month	letivery Day Year
Records, P.	ires that t signed by d be detac	þ	Part II. Other significant conditions con	tributing to death but not resultin	ng in the underlyi	ng cause give	en in Part I.		obacco use contribute	to the cause of death?  Probably 4 Donknown
cor	w requir been s should	Completed						24a. Was	an 24b, Were	autopsy findings available o completion of cause of
Re	: The law cate has	omp						autop	rmed death'	o completion of cause of ? es 2 □ No
ita	ician: The certificate ector, pag	Be C	25. Was case referres to medical				26. Place of De	1 □Yes ath (Check only o		es 2 1140
of Vital	ys dir	To B	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER	I/Outpatient 3	DOA Oth	er: 4 🗆 Nursing I	Home 5 ☐ Resid	dence 6 Other (Sp	pecify) HospicE
0	ding Ph n. After th funeral	.:uo	27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	Bb. Time of Injury	28c. Injur Worl	k?	28d. Describe h	how injury occurred	•
sio	tendi leath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М		Yes 2 □No	00/ 1 //- //		
Division	al or Attendii safter death. I Director: A d in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, tarm, street, ta	ctory, office		City or Tov	Street and Number or wan, State)	Hural Houte Number,
1	spita nours nera y fille	Medical C		sician: To the best of my knowle ner: On the basis of examination and manner stated.						
1	To the Ho within 24 I	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
			> mskajapanse	M'D		000	5746	5	11/29	5109.
			30. Name and address of person who co	mpleted cause of death (Item 23)	3a) (Type, Print)	Reister	stown,	MD. 211.	36.	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		/				
	Registr	ar	MAY 3 A 2009	12 1	1 .00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23, Helen M Parsons Physician/ November 2009 7:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Catonsville 4c. County of Death Baltimore **Examiner** 6323 Craigmont Road . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign Days 1 M 2 X F Min. 12-30-1929 Maryland 218-26-0236 79 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director FL Pasco Newport Ritchey 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2524 Brynnwood Drive 34655 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian, Was Deceuent \_\_\_\_\_ Armed Forces? 1 ☐ Yes 2 💢 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Specify.white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Packer International Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John L. Safranek Mildred M. Pfannkuchen permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Fuller 6323 Craigmont Road, Catonsville, MD 21228 Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 11-27-2009 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 21. Signature of Funeral Service Licensee m01050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown o that the death Month Year 5 Other (specify) Pregnant at time of death detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð page 2 should be Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performe death? Yes 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Daughters ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State

31. Date filed (Month, Day, Year) 2009 Registrar

29b. Signature

30. Name an

title

29c. License number

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Jacquely 2:46 AM 2009 11 21 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Mary land Mpa University of Baltimore callenter N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) SEPT. 25 1968 7. Age (In vrs. last birthday) Months 1 □ M 2 🕱 F 41 MARYLAND 219-80-7341 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1XX es 2 □ No MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 U.S.A. 1120 MYRTLE AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: BLACK 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) M & T MOBILITY Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION CUSTOMER SERVICE 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DENISE E. SMITH MICHAEL POWELL SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21201 1120 Myrtle Ave., Baltimore, Denise Powell/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Kremation 3 ☐ Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 11-28-09 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. of Funeral Service 1206 W NORTH AVENUE Ulru shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) grest Due to (or as a consequence of) Sequentially list conditions, it any, reducing to Instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last metastes Lung Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical Examiner

Examiner the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

by Funeral

Completed

Be

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ed other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic even

attending physician a for use as the burialbeen signed by the should be detached To the Hospital or Attending Physician:

P.O. Box 68760,

Division of Vital Records,

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Medical

Completed by Physician/Medical Be Certification: To

in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	4 ☐ Pregnant at time of c				Month Day Year
Part II. Other significant conditions of Metastasis	ontributing to death but not res		g cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 - Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, )
	nysiclan: To the best of my kno niner: On the basis of examina and manner stated.				and manner as stated.  d place, and due to the cause(s)

29c. License number

60617880

29d. Date signed (Month, Day, Year)

0

State Registrar

atherin 31. Date filed (Month, Day, Year) 3

29b. Signature and title of certifier

22 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5: Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Lucille Patton 11:15 A November 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore <u>Stella Maris Nursing Center</u> Timonium 8. Date of Birth (Month, Day, Year) 06/17/1914 If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2004 Months Hours 213-01-8467 95 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Expressions or other traumatic event, I'm Medical Expressions or other traumatic event, I'm Medical Expressions or other traumatic event, I'm Medical Expressions or other traumatic event, I'm Medical Expressions or other traumatic event, I'm Medical Expressions or other traumatic events. 1 ☐ Yes XXNo Director Maryland | Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 416 Goucher Boulevard 21286 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: \$ Specify: **3** Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Cora Morris Clarence Jollett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Goucher Boulevard, Baltimore, Maryland 21286 Jeffrey Patton (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park12/02/2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21 Signature of Funer | Service | consee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enice the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dise se or condition resulting in death) **Physician** Hage /Medical Due to (or as a consequence of : Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o. 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate 2 ANO 1 ☐ Yes 2 ☐ No 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2回 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) X NURSE PRACETIONER 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30/2004

State Registrar

11:15 A.M.

NOVEMBER

LUCILLE PATTON

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name od address of verson who completed cause death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

JENNIFER HAUF,

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

ristopher I	E. Pa		on State o	Maryland / Departme C <i>ertifica</i>	ent of Health a ate of Death	no ivientai ny	glerie Reg.	No 20	000 2706
Phys	sicia		egistrar . Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Peath
edical Ex		er	Christopher	E. Parrisa			Month D November 2	1, 2009 4c. County of Do	0314 hrs
		4	a. Facility Name (if not institution, give s Johns Hopkins Hospital	street and number)	4b. City, Town, Baltimore	or Location of Death		NIA	,
Fune	ral		i. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday) If Under 1 Y		8. Date of Birth(	MM/DD/YYYY) 9.	Birthplace (State or preign
Direc		1	2110-82-3672 10	1 2 F 3	6 Yrs. Months	ays Hours Min.	08-14	1-1973	Country) MD
			Jsual Residence of Decedent	10c. City, Town	or Location				10d. Inside City Limits
	ow any		10b. County		imore				1 Yes 2 No
uyland	d at once.	Director	Oe. Street and Number	100114	10f. Zip Cod	e	10g	. Citizen of What	Country?
the Ma	23a or 25a-1 Sno notified at once.	Dir.	1532 Rambleu	000d Rd.	213	39		USA	
h with	t be no	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?		Hispanic Origin? ( Spe ban, Mexican, Puerto		14. Race - A White, e	merican Indian, Black, tc.
er deat	r mus			1 Yes 2 No f Yes, Give Year	1 Yes 2	No specify:		Specify:	31ack
wrs aft	amine	d b	15. Decedent's Education (Specify only	v highest grade completed) , 16a.	Decedent's Usual Occu during most of working	ipation (Give kind of w		6b. Kind of Busin	
<b>6</b> n 72 hc	an "na ical Ey	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	uto Sake			Car D	ealership
<b>5-0036</b> Iled within 7 Hygiene.	ther than e Medical	E -	17. Father's Name (First, Middle, Last)		140 00 le	18.Mother's Name	(First, Middle, Ma		Card Dille
215 be filed ntal Hy	marked other than c event, the Medical	Be		arrison, Sr.		Charle		1es 64	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	it; If item 27 is marked other traumatic event,	٦٩	19a. Informant's Name/Relationship (Ty	pe, Print) 19 19 19 19 19	b. Mailing Address (S	mblewoo		er, City or Town, : Ra (Lima)	State, Zip Code) (C1 MD ZIZ39)
and 2 sho	If item 27 is her traumati	-	20a. Method of Disposition	20b. Place	of Disposition (Name o	cemetery,	Date	20c. Location - Ci	
more, Pages 1 a	of her =				tory or other place) Memorial	Park 119	28-09	Balling	xe, mb
<b>Baltin</b> permit. P	Important; injury or of	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens		22. Name and Add	ress of Facility VO	mylnin a	. Gree	neduneralot
			23a. Part I. Enter the disease, or compli	Here_	18128 L	berty L	r respiratory arres	t, shock, or heart	Houring MSZISS
Physic M			failure. List only one cause on each	ch line.	ot enter the mode of dy	mg, 3001 03 30. 000 0		.,	Between Onset and Death
xami	ner			Head Injuries Due to (or as a consequence of):					
		١	Sequentially list conditions, b.	Due to (or as a consequence of):					
		miner	cause. Enter Underlying Cause						
ly de de	nsit	Exa	events resulting in death) Last d.	Due to (or as a consequence of):					
Records, P.O. Box 68760, The law requires that the death certificate be executed	ysician and burial - transi	Physician/Medical	UNPENDED	AMENDED Item#20b,pe	orFH C897	1 / 30 / 09 W	S		
<b>760,</b>	physic the bur	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	y	3 Ectopic pregna		23d. Date of do	elivery Day Year
<b>6876</b>	e attending phy for use as the	cian	past 12 months?	- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<ul><li>Fetal death</li><li>Other (Specify)</li></ul>	3 Ectopic pregna	ancy	Monar	50,
<b>Box</b> e death c	\$ B	hysi	1 Yes 2 No 9 Unknown	9 Unknown		and the state of t	23e Did to	pacco use contrib	ute to the cause of death?
P.O.	20		Part II. Other significant conditions	contributing to death but not result	ng in the underlying ca	use given in Part i.			Probably 4 Unknown
ds, l	e has been signed t e 2 should be deta	Completed by					24a. Was a		ere autopsy findings available or to completion of cause of
e law r	e has b ge 2 shu	mple.	· ———				perfor	med? de	ath?  Yes 2 No
8 # #	certificate l ector, page	ပိ	25. Was case referred to medical		26.	Place of Death (Check			
of Vital Records, ng Physician: The law requir	this ce	То Ве	1 ✓ Yes 2 No	lospital: 1				Residence 6	Other:
n of	After funera	on:	27. Manner of Death  1 Natural 5 Pending	(Month Day Year)	. Time of Injury 280 09 hrs 1	. Injury at Work?  Yes 2 ✓ No		iow injury occurre ixed object co	
Division tal or Attendi rs after death.	ector: by the	icati	2 Accident Investigation	on 28e Place of Injury - At home.	farm, street, factory, of				or Rural Route Number, City
Div ital or	ral Di	Certification:	3 Suicide 6 Could not determined	be			or Town, S 4000 The Alar	tate) meda, Baltimore	e, MD
ie Hosp 124 hou	To the Funeral Director: After this certificompletely filled in by the funeral director,	cal C	29a. Certifier	ian: To the best of my knowledge, d	leath occurred at the tir	ne, date and place, an pinion, death occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
To th	To th comp	Medical	29b. Signature and title of certifier	and manner stated.		icense number			d (Month, Day, Year)
		7.0	Tolana.	111/		D.C.M.E.		November 2	21, 2009
			30. Name and address of person who			D-10 14D 0	1001	I	
- V				stant Medical Examiner  32. Registrar's Signature	111 Penn Street,	Baltimore, MD 2	1201		<del></del>
R	S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 3 0 20	109 Registrar's Signature	parked				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Penn ugene /Medical November 2009 4a. Facility Name (If not institution, give street end number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dina: Hospital of Baltimore

5. Social Security Number 6. Sex. Baltimore
Privear If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 M 2□ F Months Days Hours Min. 579.72.3250 53 DC Director 08/02 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be retified at Rattimone Randallstown 1 □ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hathaway Drive, Apt.D 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Body tender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Eugene Oates LOUISE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24133 permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Shelby R. Forebee-Penn (Wife) 3614 Ann Hathaway Drive, Apt. D Randall stown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hyattsville, MD Harmony Memorial Park 12/01/09 22. Name and Address of Facility Vaughn C. Greene Funeral services 8728 Liberty Road Randowstown MD 21133 21. Signature of Funeral Service Licensee Vaux- ( 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of Hypertension /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 ettending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate ha 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 059062 November 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) W Baltimore MA 21215 2401 Belvedere 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 November 1:40 Рм Kenneth Roy Peifer 4b. City, Town, or Location of Death 4c. County of Death Montgomery Derwood 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)

December 20, 1946 Washington, D. C. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days 62 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Montgomery Derwood 10f. Zip Code 10g. Citizen of What Country? 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 □Yes 2 No Specify. Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) Public Schools Business Manager 18. Mother's Name (First, Middle, Maiden Surname) Bertha Cropp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18512 Azalea Drive, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) November 21. 20c. Location - City or Town, State 2009 Bethesda, Maryland Montgomery Crematorium, Inc. Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Stillen M01360 Approximate Interval Between Onset and Death Metastatic Renal Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f shov

72 hours after

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

certificate be executed sician and burial-trans the attending physician hed for use as the buria P.O. Box 68760 à Division of Vital Records, has

page 2 this certificate After thi

Hospital or Attending Physician; 24 hours after death.
Funeral Director: / etely filled in by the fi

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/Medical 4a. Facility Name (If not institution, give street and number) Examiner 18512 Azalea Drive 5. Social Security Number 219-46-7723 Usual Residence of Decedent 10a. State Director Maryland 10e. Street and Number 18512 Azalea Drive Funeral 11. Marital Status 1 ☐ Never Married 2 X Married þ 3 Widowed 4 Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 2 <u>William Peifer</u> 19a. Informant's Name/Relationship (Type. Print) Marilyn A. Peifer / Wife 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 19, 2009 D0061083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive #300, Rockville, Maryland 20850 Paul M. Thambi, M.D. 31. Date filed (Month, Day, Year) 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 24. 2009 2:56  $A^M$ November Physician/ Peter Ernest Panarites Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) (Month, Day, Y 5. Social Security Number New York Hours Days Min. **Funeral** 1 X M 2 D F 79 Yrs 052-28-9959 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County Director 1 Yes 2X No permit. Page 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. North Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20852 6937 Race Horse Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status was becedent Ever in 0.5.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1954–1956
Year or Dates. 1 Never Married 2 K Married þ 1 ☐ Yes 2 X No Specify: Specify: White 21215-0036 3 🗌 Widowed 4 🔲 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Law 5+ Attorney 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland Christine Giannou ည Ernest Panarites 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6937 Race Horse Lane, North Bethesda, MD 20852 Helen Panarites /Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date November 28, 2009 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 22 Name and Address of Facility neral Home/Bethesda-Chevy Chase, Inc. of Funeral Service Licenses 21. Signaty 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Cardiovascular Disease immediate Cause (Final disease or condition resulting in death) Physician/ Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, it any, leading to immediate Due to (or as a consequence of): Examine it any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy Year Month in the past 12 months? Pregnant at time of death ☐ Pregnam ☐ Unknown 2 🗌 No ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be der 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 🗌 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed's 2 😿 N certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital 1 Inpatient 2 K ER/Outpatient 3 IDOA 2 X No 1 Yes |은 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death work? 1 ☐ Yes 2 ☐ No 5 Pending 1 X Natural M Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 I Director: After this d in by the funeral di Certificate: Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 24, 2009 7663 Tun wis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NW, #200, Washington, DC 20036 19th Street, 1120 M.D. Ace Lipson, 31. Date filed (Month, Day, Year) 32 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician   Virginia M. Plum   Plum   Compared   Comp				State of Maryland / Dep  1 - For State Registrar Ce	artment of Health and N	Mental Hygiene Reg. No	2009 37865
Try state of the control of the cont						2. Date of Death	3. Time of Death
Shady Crove Adventist Hospital  Rockville  R		_		Virginia M. Plum		November 2	3, 2009   11:36 Рм
Social Executive Framework   2 mm   3 mm   2 mm		Examin	er				1 1000
371—30—4626   See   150. Courts   150. City, Internal Courts   150. City,							
The state of the s				I I MOME		October 23,	1933 Michigan
23a. Part 1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate the death of the cause of the		, wo					40d Inside City Units
23a. Part 1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate the death of the cause of the		ryland I-f shu ied at	ctor				1 🗆 Yes 2 🕅 No
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23a. Part 1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate the death of the cause of the		teath tems	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	
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23a. Part 1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate the death of the cause of the	pu	ital Hy ed oth					Surname)
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23a. Part 1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate the death of the cause of the	<b>∑</b>	2 sho Ith an 27 is 27 is trau					
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23a. Part 1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate the death of the cause of the	<u>m</u>	Page nent c ant: If ury or		TEM Buriai 2 Cremation 3 Chemoval nom State	aven Cemetery 28,	2009 Silv	ver Spring, Maryland
Sequentially list conditions, cause of meat and Death of Cardiac Arrythmia    Cardiac Arrythmia   Cardiac Arrythmia   Cardiac Arrythmia   Cardiac Card	Balti	permit. Departr Imports any inji		21. Signature of Funeral Senter Licensee  M01305	2 Name and Address of Facility Obert A. Pumphrey Fune O West Montgomery Ave	eral Home/Rock enue, Rockvill	ville, Inc. le, Maryland 20850–2805
Cardiac Arrythmia   Card				23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between
Secure trailing in conditions, and the secure trailing in death   Last   Due to (or as a consequence of);   Due to (or	-			disease or condition Cardiac Arrythm	ia		Onset and Death
Sequentially list conditions are proposed to the part of the part				Due to (or as a consequence of).	actinal Blooding		
Cause (Disease or Injury Institutional development of the Company			Jer	Sequentially list conditions, b. Due to (or as a dos sequence of):	estinai bieeding		
Specific   Specific	1.	ansit	amir	Cause (Disease or linjury			
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D0062435 November 24, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sayed Elsayyad, M.D. 10110 Molecular Drive, Rockville, Maryland 20850	9	nte be hysici he bu		d			
D0062435 November 24, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sayed Elsayyad, M.D. 10110 Molecular Drive, Rockville, Maryland 20850	387	artifica ding p	/Me	23c If you outcome of pregnancy			2024 Bata of delivers
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Elsayyad, M.D. 10110 Molecular Drive, Rockville, Maryland 20850		To the To the comp	-	29b. Signature and title of certification (Control of Certification Control of Certification Control of Certification Control of Certification			
Sayed Elsayyad, M.D. 10110 Molecular Drive, Rockville, Maryland 20850				1 5) / M M D		Nove	ember 24, 2009
State Registrar  31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	5		Sayed Elsayyad, M.D. 10110 Molec		ville, Mary	land 20850
THE PARTY OF THE P				31. Date filed (Month, Day, Year)  32. Fegistrar's Signature	harles		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2:20 PM Herbert 1514 2009 rearson Newson521 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bult-more Max N Medica niversity of Lende1 Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 296-26-1458 IŃ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State or items 23a or 28a-f show event, the Medical Exactings must be notified at 1 ☐ Yes XX No Director MD Anne Arundel Clen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 7028 Cresthaven Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1952 "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Office Clerk s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Helen Garringer ဂ Jesse Arlington Pearson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau 303 E. Main St., Union City, OH, 45390 Blaine Pearson Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 □ Removal from State 5 ☐Other (Spec Nov 20, 2009 Union City, IN 4 □ Donation Pleasant Hill Cemetery TO STEPPEN PENSO 22 Fink and Address of Facility, P.A. 426 Crain Hwy S., Glen Burnie, MD M01148 Gregor Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. It ter the dise shock, or leart illustration art one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** wrter, JPG15 Drungy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 🗆 Yes 2 No hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 □ Yes 2 L No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and P.O. Box 68760. Division of Vital Records,

completely filled in by the Hospital 24 hours a

Medical Certification: To

27. Manner of Death 1 🛮 Naturai 2 🔲 Accident 6 ☐ Could not be 3 Suicide

29b. Signature and title of dertifier

4 Thomicide

29a Certifier

30

5 Pending investigation

determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 2 0

29d. Date signed (Month, Day, Year)

/	/	/	1		W		
. Name and addres	s of p	erson who	mpleted	cause of	death	(Item 23a)	(Type, Pr

31. Date filed (Month, Day,

Registrar DHMH 17 Rev 1/2001

State

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar 37867 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 Day 20 89 Physician GEORGE MAN J0548 2:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARKVILLE BACTIMORE 8007 Ridgely Oak Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country Maryland Months Days 1 M 2 F 71 212-36-7052 Director April 14, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, Ite Wodfoll Eventing must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8007 Ridgely Oak Road Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Michael Rettman Mildred Pettit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Retuman/Wife 8007 Ridgely Oak Road, Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 25. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematroy, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCAROIAL Physician DAYS disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if ny, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ficate has been si r, page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No performed No autopsy After this certificate funeral director, page 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760, P.O. of Vital Records, Division

Registrar

Kucha

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

BAR

CRNP

C

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-25-2009

09-09085 Archie Reynolds Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ie Reynolas	1- For State  Certificate of Death  Reg. No. 2009 378									
Physician/ lical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year November 22, 2009 3. Time of Death Month Day Year November 22, 2009									
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 706 E. 35th Street  4c. County of Death Baltimore									
Funeral Director	5. Social Security Number 20-80-1830 1 Xm 2 F 49 Yrs.   The security Number 20 F 49 Yrs.   The security Number 20 F 49 Yrs.   The security Number 20 F 49 Yrs.   The security Number 20 F 49 Yrs.   The security Number 24 F 20 F 30 F 30 F 30 F 30 F 30 F 30 F 30									
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limit									
Maryland 28a-f show d at once	MD N/A Baltimore									
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 706 E. 35th Street 21218 USA									
MD 212150036  42 should be filed within 72 hours after death with the Maryland the and Mental Hygene. In 27 is marked other than "natural", or items 23a or 28a-f she anmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black Specify:									
ural", miner	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Business/Industry									
Jo nin 72 hours e. than "natu dical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Security									
led within 7 Lygiene. other than the Medica	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)									
Inforce, IND Z1Z13-0030 Pages I and 2 should be filed within 72 hours afte ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Cecilia Reynolds-Mother 6225 York Road Apt N 422 Balto, MD 21212  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Crematory or other place)  20b. Place of Disposition (Name of cemetery, Crematory or other place)									
Daitimore, permit. Pages I an Department of Hes Important: If itel injury or other tr	4 Donation 5 Other Specify: Greenmount 11-30-09 Balto, MD									
Dalti Departin Importi injury c	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H									
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Retygen Onset an									
/Medical xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Death  Death  Death  Death									
je je	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):									
nted d ansit Examine	events resulting in death) Last Due to (or as a consequence or).									
60, ate be executed bysician and burial - trans	Xunpended 23a,27,28a-f,permE, g898 12/10/09 TT									
<ol> <li>BOX 68 / 60,</li> <li>the death certificate be executed</li> <li>by the attending physician and cheef for use as the burial - transit</li> <li>Physician/Medical Ex</li> </ol>	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)									
box e death the atte	1 Yes 2 No 9 Unknown g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death?									
Es that the designed by the detached	1 Yes 2 No 3 Probably 4 🗹 Unknow									
aw requir has been s 2 should t	24a. Was an autopsy findings availa prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No									
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Vital hysician this cert I directo	1 V Yes 2 No I impatient 2 ENOutpatient 3 DON 4 Italiang Home 3									
in of nding Ph. h. : After t e funeral										
DIVISION O Spital or Attending tours after death. neral Director: Aft filled in by the fune	2 Accident Investigation   Investigation   Accident   Accident   Investigation   Investigation   Suicide   Accident   Investigation   Suicide   Accident   Investigation   Investigation   Suicide   Accident   Investigation   Investigation   Investigation   Investigation   28f. Location (Street and Number or Rural Route Number, Controlled   Co									
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	1 293 Certifier									
To the Ho within 24 To the Fu complete	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)									
	O.C.M.E. November 23, 2009  30. Name and address of person who completed cause of death (Item 23a)									
$\phi$	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Stat	ae 31. Date filed (Mogth, Daz 100) 32. Registrar's signature									

OCME

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Month Day Year November 26, 2009 **Physician** 2:40 Malave Rivera Maria Nieves /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's New Carrollton 6416 Fairborn Terrace If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 71 581-90-5471 08/05/1938 Puerto Rico Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Prince George's 1 ☐ Yes 2 ☐ No New Carrollton Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20784 6416 Fairborn Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married XXYes 2□No Specify: Puerto Rican Maryland 21215-0036 White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygient Important: If them 27 is marked other that any injury or other traumatic event, I'm 1 once. Employment Services Specialist **Government** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francisca Rivera Rafael Malave 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6416 Fairborn Terrace, New Carrollton, MD 20784 Migdalia E. Malave / Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 11/28/2009 Woodbine. MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO BOX 1314, Baltimore, MD 21203 of Funeral Service License Dorota Marshall uelo Marshall Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and ach line. Immediate Cause (Final CANCER **Physician** REATIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be execute sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Dav in the past 12 months? 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? δ sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Jepital o.
4 hours after dea.
Therefore: After a prector: After a prector of the fire of the fire and a prector of the fir 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057984 November 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RM 940; BALTIMORE, MP LUIS DINZIMD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 () () 9 Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year mond /Medical ovember 2009 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Good Samaritan Hospital Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 M 2 □ F Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinations to must be multified an angione. Director 1 Yes 2 □ No Himore 10e. Street and Number 10g. Citizen of What Country? orth bourne Funeral Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced timoye, Maryland 21215-00 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cellege (1-4or 5+ Father's Name (First, Middle, Last) Be မ mant's Name/Relationship (Type. Print) Wile 19b. Mailing Address (Street and Number & Bural Route Number, City or Town, State, Zip Code) 101 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Hemoval from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee U015 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of complications that caused the death. Do not enter Approximate Interval Between Onset and Death Immediate Cause (Final Sclenotic **Physician** Cindlo Visentor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or sician and burial-transit be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 C Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 icate has been si 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate of Vital 2 No 1 □ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation the Hospital or Attending 1 Natural 24 hours after death. • Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) Voicenter 22, 2009 Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

SCRUGES

31. Date filed (Month, Day, Year)

Mus)

32. Registrar's Signature

5601 Loch Raven Boulevard, Baltimore Maryland 21239

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AMEND TITEM# 18&20b, perFH, G898, 12/14/19, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ZIOPM OBINSON 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Envoy of Pikesville Nursing Home Baltimore Pikesville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M **X**□ F 97 247-16-3234 Director 09 06 SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any pine. 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X es 2 No Baltimore Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 U.S.A. 5711 Rockspring Road by Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2√□ No Specify: Specify: 3 X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Domestic <u>Private</u> 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Kennedy John Woodard 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Woodard-Sister 5711 Rockspring Road, Baltimore, Md21209 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodnierer Cemetery Woodmore 11/30/09 Detroit, MI 22. Name and Address of Facility 21. Signature of Euneral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 ) mette 23a. Pert1. Ent.r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ERI **Physician** VASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Yes → No 9 Unknown in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) KICRNI and manner stated.

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, signed by the a the Hospital or Attending Physician: director. 24 hours after death Puneral Director: To the

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Fran

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Registrar's Signature

DHMH 17 Rev 1/2001

Reuster8

29c. License number

29d. Date signed (Month, Day, Year)

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			For State	State	of Maryla		artment of		and M	lental Hy	/giene			
			Registrar			Cer	tificate of	Death			Reg. No.	200	9	37872
	Physicia	ın/	Decedent's Name (First, Middal     Virginia Ann	,						2. Date of De Month		Yea	r	3. Time of Death
,	Medic Examin		4a. Facility Name (if not institution		nher)		4b. City, Town,	or Lagation	of Dooth	NOVEM!		2 200		7105 AM
	/ Examin	CI	Shady Grove Ad	. •	,	1	Rockvil		or Death			County of De		
	Funeral		Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	If Under		8. Date of Bir	rth	9. E	Birthpla	ce (State or Foreign
	Director		144-34-3533	1 □ M 2 🛛 F		67 Yrs.	Months Days	Hours	Min.	October	7, rear 194	2 F1	ountry Ori	da
	nd thow	_	Usual Residence of Decedent  10a. State 10b. County	/	10c.	City, Town or Loc	ocation						10d	I. Inside City Limits
	faryla 8a-f s tified	Director	Maryland Monte	gomery	G	ermanto	n							1 ☐ Yes 2 🔀 No
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	n with	Funeral	21331 Emerald	Drive	-		20876				Unite	ed Sta	tes	
	deatl r iterr iner n		11. Marital Status	12. Was Dece Armed Fo	rces?		Vas Decedent of I	Hispanic Ori an, Mexicar	igin? (Spec	cify Yes or No- Rican, etc.)	1	14. Race - An Black, Wh		
39	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Mal 3 🔀 Widowed 4 ☐ Divorced	If Van Cit		1	☐ Yes 2 🛣 N	o Specify:	:		8	Specify: W		
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2	ed within Hygiene. other thar	Be C			4	Regis	tered Nu	rse			Nur	rsing		
anc	oe filed intal Hy ced oth	10 E	17. Father's Name (First, Middle, John Iseldyke	Last)						(First, Middle,		urname)		
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Š	12 sh alth ar 27 is r trau		John J. Reinha		nn n		g Address (Street Emeral						•	•
ore,	e 1 and 2 should be file of Health and Mental I f item 27 is marked o r other traumatic eve		20a. Method of Disposition		20b	. Place of Dispos	sition (Name of	)	D	ate		cation - City of		
<u>m</u>	Page ment ant: I		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (	3 ☐ Removal from Specify)		-	natory or other pla rematorium	· · · · · · · · · · · · · · · · · · ·	Nov.20	759	  Beth	esda,	Mar	vland
Baltimore, Maryland 21215-0036	permit, Page 1 a Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service I	Licensee	_	Rol	Name and Addressert A. Pun West Mont	ess of Facilit	ty Funera	1 Home/R				
	<u></u>		1 July	13em	MO1	548 300	West Mont	gomery	Avenu	e, Rockv	ille, l	vary Ian	1 208	350
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	Physician/ Medical		disease or condition resulting in death)	a. Sim	or as a conse	4NDROS	HE							nset and Death
4.5	Examiner					SACTES	BAC	TERE	MIA				0,	AYS
		iner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying	- 0	or as a conse	NOTE OF THE PERSON NAMED IN		, 10, 500						
ξ.	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events											
•	ate be executed ohysician and the burial-transi		resulting in death) Last	Due to (	or as a conse	equence of):								
		edical		d										
89	certific nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of preg	nancy					1 2	3d. Date of d	lalivan	
Box 68	eath e attel	icia	in the past 12 months? 1  Yes 2 No	4 ∐ Pregr	nant at time o	etal death 3 of death 5	Ectopic pregnan Other (specify) _	су				Month	Da	y Year
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ဝဘ္က	has b	Completed by	my po weak lation	Hyndrom.	1 61		ACE phalo	pathy	_	24a. Was autor	osy	24b. Were a prior to death?	comp	findings available letion of cause of
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ion	eath. or: Af the fu	lfica	1 Natural 5 Pendir 2 Accident Investig 3 Suicide 6 Could	gation	., <i>Day</i> , roar,	injus y	M 1 🗆	Yes 2	No					
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Uneck Z L Medical E	xaminer: On the basi Nurse Practioner:	is of examinat	ion and/or investi	dation, in my opini	on, death oc	curred at t	he time date a	nd place a	and due to the	cause/	s) and manner stated.
	Vithii Vithii Cong		29b. Signature and title of certifier				29c. Licens	e number			29d. Date	signed (Mon	th, Day,	Year)
				CHANACE	ES		29	453			Nov	emper	-10	e, 2009
	20		30. Name and address of person	who completed cause	e of death (Ite	em 23a) (Type, Pr	129 6ROVE	Λ.	0	(a) (b) (c)	^	1 ,0	2	
L ex	Stat	<u>.</u>	ALGN S. CHA 31. Date filed (Month, Day, Year)	32 A	gistrar's Sign	ature a	OFFILE	FU	KUCK	ruich	MA	CC'S.	30	
	Registra		NOV 3 0		Alad a	1. 10	Made							

DHMH 17 Rev 7/2009

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			For State	State o	f Marylar				and Mental H	ygien		07072
			Registrar  1. Decedent's Name (First, Middle	e, Last)		Cer	tificate of L	Jeath	2. Date of [	Reg. N	.2009	37873
	Physici Medi	cal	ESFIR  4a. Facility Name (if not institution			RUBINS			NOVEME	Г	23, 2009	2:20 A M
+	Exami	ner	GILCHRIST HOSP	ICE CARE	iber)		4b. City, Town, or TOWSON	r Location	of Death		c. County of Death	
	Funeral Director		5. Social Security Number 216-41-1403	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. I	last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of E Min. (Month, I 10-13	irth	9. Birthp Count	lace (State or Foreign ry) BELARUS
	and show at	5	Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc	eation			- 192		Od. Inside City Limits
	Maryla 28a-f s	irect	MD N/A			TIMORE						1 X Yes 2 No
	with the 23a or 1st be r	Funeral Director	10e. Street and Number 6978 MARSUE DR	[VF. #1A			10f. Zip Code 21215				Citizen of What Coun	ry?
	r death r items iner mi		11. Marital Status	12. Was Dece	dent Ever in U.S		vas Decedent of Hi	spanic Origin, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	US	14. Race - America Black, White, e	
0036	urs afte ural", o al Exam	ted by	1 Never Married 2 🔀 Mar 3 Widowed 4 Divorced		9		☐ Yes 2 🗶 No				Specify: WHI	
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	TOE	17. Father's Name (First, Middle, I EFIM	.ast)	СН	ERCHES		18. Mothe	er's Name (First, Middle	, Maiden	,	NOWN
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-	Medical Examiner		disease or condition resulting in death)	a. Due to (o	r as a consequ	ence of):	4					with
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	certification of the see as the s	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan	nCV						
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Ita	sician: certifica rector, p	Be l	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:					1 U Yes (Check only one)	2, <b>2</b> No	1  Yes 2	□ No
01	ng Phys fter this ineral di	ate: To	27. Manner of Death  1/2) Natural 5 Pending	28a. Date of	patient 2  E injury 2 Day, Year)	28b. Time of injury	3 DOA Other  28c. Injury a work?	_4 ⊔ Nur	sing Home 5 Resident			nospice
Division of	Attending transfer death, sector: A sy the fu	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determin	ation ot be				es 2 🗆 N		``		
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, :	to one hospital or Attending Physician: The law within 24 hours after death,  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 (	Med	only one) 3 Certifying	aminer: On the basis	of examination a	and/or investio:	ation in my opinion	death acc	ace, and due to the ca urred at the time, date a and place, and due to th	nd place	manufation and the control of	e(s) and manner stated. d.
	Verity CO To To To To To To To To To To To To To	2	29b. Signature and title of certifier	(Gra			29c, License r	number 32	03	29d. Dat	re signed (Month, Day	/, Year)
		3	80. Name and address of person w	ho completed cause of	of death (Item 2	23a) (Type, Prir	t) (damle	()- ()	POWSON			75 0007
	State	-	1. Date filed (Month Day, Yas)	32. Reg	istrar's gnatur	TO NO	P	70	TONSON	1411		
	Registra		MA 9 0 5008	Lewis	19.19	TO COLOR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2Siles of Mar (Rand / Department) of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 2. Date of Death Oy. 22,2009 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** William E. Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Location of Death Examiner Baltimore 403 N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. 02/03/1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 81 Maryland **Director** 219-20-9038 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at 1 ☐Yes 2 X No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 912 Catawba Court 21227 United States by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Telephone 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ပ William G. Robinson Unknown permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is mark any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Esther F. Robinson (Wife) 912 Catawba Court, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 11/24/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFAREDON **Physician** 40 MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably JUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy perform 1□Yes 2□No filled in by the funeral director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat e Funeral Director; 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CURTIS

mi 32 Registrar's Signature

Robinsor, Willia

marko

0051865 November 22, 2009

Agnes Hospital BALTIMORE, MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Thor S. Ramsland 12:50 A<sup>M</sup> 2009 NOVEMBER 27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 X M 2 □ F Director 219-28-5832 Jan 6, 1932 Norway Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once. 1 ☐ Yes 2 No Director Md. Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5512 Sweet Air Rd. 21013 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married RAMSLAND, Tho Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Administration Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sverre B. Ramsland Thordis S. Soyland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eleanor Ramsland/ Wife 5512 Sweet Air Rd. Baldwin, Md. 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Hilltop Service Co. 11-28-09 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licer 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UROUS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any, heading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760 physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Ye ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s the Hospital or Attending Physician: The 2 **N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) D41406 2712009 30. Name and address of person who completed gouse of death (Item 23a) (Type, Print) HARLES BALLI MD 21204 31. Date filed (Month, Day, Year) NOV 3 0 2009 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of F tificate of L	Health and M Death	lental Hygi	ene 2009	37876
	Physicia Medic Examin	cal	1. Decedent's Name (First, Middle, Las		RULE		Location of Death	2. Date of Death Month	Day Year	
م م	Funeral Director		<u> 213-26-9866                                     </u>	W MEDO4L CENT × 7. Age (In yrs. → M 2 🖾 F	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	9. Bir 1930 Man	thplace (State or Foreign untry) cyland
	Maryland 28a-f show lotified at	irector	Usual Residence of Decedent  10a. State 10b. County  Md •		ity, Town or Lo Balti	more Ci	ty			10d. Inside City Limits 1 Yos 2 □ No
	leath with the Items 23a or er must be r	<b>Funeral Director</b>	10e. Street and Number  360 Gusryan St  11. Marital Status	reet  12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	10f. Zip Code  2122	24 ispanic Origin? (Spe n, Mexican, Puerto		U.S.A.  14. Race - Ame	rican Indian,
5-0036	hours after c 'natural", or dical Examin	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ec (Specify only highest gra	1 Yes 2 XNo If Yes, Give Year or Dates.	16a. Deced	Yes 2 X No	Specify:	- 14	Specify: Wh:	ite
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene, it has the marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	æ	Elementary/Seconday (0-12)  12 th  17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	life. Di	ne Make	turing most of working  18. Mother's Name	ng	Own Hor	
Aarylan	should be fi n and Menta 7 is marked raumatic ev	o	George Arnold  19a. Informant's Name/Relationship (Ty,	•			and Number or Rura		City or Town, State, Zip	
more, 1	Page 1 and 2: ment of Health ant: If item 27 ury or other tr		Clement Ruley,  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other plac	e) Nové	iliber 2	0c. Location - City or	land21224  Town, State  , Maryland
Balti	permit. Page 1 Department of Important: If i any injury or o	85 3	21. Signature of Funeral Service License 21. Signature of Funeral Service License 22. Part 1. Enter the disease, or comp	larly	122	Name and Address 201 Dun (	ss of FaciliKacz dalk Ave	orowski enue Bal	l Funera Ltimore,	home,P.A. Md.21222
2	hysician/ Medical	Š	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	EVD	ir the mode of dying	g, such as cardiac o	r respiratory arrest	s	Approximate Interval Between Onset and Death
	Examiner Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscose or impary	b. Due to (or as a conseq	juence of):					
09/	cate be executed physician and the burial-transi	dical	d							
X R R	sician; The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No g □ Unknown	23c. If yes, outcome of pregnant 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
	law requires that the nas been signed by the s 2 should be detach	by	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	the cause of death?
æ	in; The law re ifficate has bo or, page 2 sh	e Completed	25. Was case referred to medical		_	26 Pla	ace of Death (Check	24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
n of Vital	his his	cate: To Be	examine 1 No Per S 2 No Pending 2 Accident Investigation	Hospital: 1 ☐ Inpatient 2 ☑ 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 DOA Othe	er: 4 Nursing Hor	,	ce 6 Other (Specinjury occurred	ify)
Division of	oital or Atter ours after dea oral Director illed in by the	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)			City or Town, S		<u> </u>
Ď	To the Host within 24 ho To the Fune completed f	Medical	(Check 2 Medical Examin	cian: To the best of my know er: On the basis of examination Practionar To the bast of m	in and/or invoct	igation in my opinio	n doath againmed at	the times wheth and	ما ينظم مقام بالداميم المحمل	/ a\ a a -
			30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, P	100°	20689	estillar 1	d. Date signed (Month) 17/24/2 Medital (	20 9 Con for
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 3 () 2	32. R distrar's Signa	A. A	barker	~///	,		,,,,,,,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:35 PM **Physician** 25-2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner Warcester Hospital Berlin Hantic General Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2**X**□ F March25,1920 Maryland Director 217-18-3083 89 Usual Residence of Decedent 11/25/09/2 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1 X Yes 2 □ No item 27 is marked other than "natural", or items 23a or 28a-f si other traumatic event, the Medical Examinat must be notified Director Maryland Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13801 Coastal Highway U.S.A. 21842 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No DOD If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Education Clerk 03/25/1920 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel A.Wright Howard Edwin Holland and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. Deborah Jane Smith/Daughter13801Coastal Highway, Ocean City, Maryland Pages 1 L 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 11 - 30 - 091 ☐ Burial 2 XCremation 3 ☐ Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremationServices 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael P. margullo 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sepsis days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 308 Due to (or as a consequence of): that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trans Due to (or as a consequence of): 68760 00 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) P.0. 9 Unknown いずた 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? tes Mellitus 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 2. No 1 TYes Dorothy Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. To the 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier D0059945 MO Name and address of person who completed cause of death (Item 23a) (Type, Print) 33195 Lighthouse Road, Selbyville, Delaware 19975 MO 31. Date filed (Month, Day, Year) 2009 32 Registrar's Signature State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Robert Clarence Smith 24,2009 November /Medical 9:45A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Heart Home Assisted Living Lutherville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Days Hours 1 X M 2 □ F Months 87 Director 18,1922 216**-**18-3110 June Mary land Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show solical Examiner rugst be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 XNo Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14106 Cuba Road 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XIVES 2 No. 3/13/43

Yes, Give 03/13/43

Year or Dates 02/06/46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 2 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 □ Divorced Completed the Madical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) N/A permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Mental Injury or other traumatic event, If a Men Elementary/Secondary (0-12) Machinist Die Craft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Robert Smith Elsie Cardelia Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Smith/Son 10642 Anglo Hill Road Cockeysville, MD 21030 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory of other place)
Cuba United Methodist
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Cockeysville, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 21. Signature of Fur Inc. Michael J. Flagle 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Menos disease or condition resulting in death) /Medical Due to (or as a cons- Lence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Dav Year 5 Other (specify) Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 - Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only one) the 29b. Signature and title of contifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto. Md 21204 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State

Registrar

Division of Vital Records, P.O. Box 68760

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

		•	for State of Maryland / Department of Health at Certificate of Death	ina Meni		g. No. 2009	37879
	Physici	an	1. Decedent's Name (First, Middle, Last)		ate of Death Ionth	Day Year	3. Time of Death
1	/Medio		Mary Jane Schwab  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of	f Death	No	v 19, 2009 4c. County of Death	4:50 A <sup>M</sup>
1	Examir	er	5173 Downwest Ride Colum				oward
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		ate of Birth fonth, Day,		place (State or Foreign
-	Director		508-82-6447 53 Yrs.	141111.		4, 1956	NE
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryi -f sho	ţō	MD Howard Colui	mbia			1 □Yes 2 No
	n the	irec	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Wedgel Evan from matter mattiful at	la D	5173 Downwest Ride 210	)44		U.S	S.A
		Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	jin? (Specify Y Puerto Rican,	es or No- , etc.)	14. Race - Amer Black, White,	
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Maryland			Charles L. Walthall Spouse 5173 Downwest Ride Co				p Code)
	of Fe Ta		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		0c. Location - City or T	own, State
E	Ö ← − 0		1 ☐ Burial 2 ☐ Scremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Atlantic Crematory, LLC	Nov 20,	2009	Glen B	urnie, MD
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Records,	has b	Completed		2	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
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ion	Attending r death. sctor: After by the funer	atio	1 Matural 5 ☐ Pending (Month, Day, Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ N	40			
Division	i or Atten after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Stre	eet and Number or Ru State)	ral Route Number,
	oitai o urs af eral D						
	Hospital of 24 hours a Funeral Dietely filled i	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and physician and/or investigation, in my opinion, death and manner stated.	d place, and d th occurred at	the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier 29c. License number		29	d. Date signed (Month	, Day, Year)
	- > - 0		I Edward & Free MD 12360	01	1	DOU 19	2009
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		\ .	10. 0	212141
			Edward Lee Mp 11750 Charter Dr. Ci	dun	bla	IND C	1044
	Sta Registr		31. Date filed (Month, Day, Year)  32. Begistrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 37880 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:05 A<sup>M</sup> 2009 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 2, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🖾 M 2 🗆 F Months Hours 215-40-4899 Maryland Director 1942 67 Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4504 Oakleigh Drive 21102 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 X Yes 2 No Maryland 21215-0036 White If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Nidowed 4 ☐ Divorced Completed and Mental Hygiene.
is marked other than "natural"
aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Distiller Joseph E. Seagrams 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe -Orville Smith Ann Dunphy permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca A. Ebberts Daughter Nova Drive; Manchester, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Holly Hills 11/30/2009 4 Donation 5 Other (Specify) Baltimore, MD 22 Name and Address of Facility **Sterling Asht**on Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 LIC # Signature of Funeral Service NO1537 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy Brain performe Was case rate rad to mexaminer? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 2 Other: Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death 28a. Date of injury 28b. Time of Certificate: After 4 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 2 🗆 No hours after death uneral Director: A Investigation Accident completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital thin 24 hours of the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 25052

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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Registrar's Signatu

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30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle\_Last) 2. Date of Death Month Vovember 20M K 050 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Raven VA N/C Baltimore N/A Loch If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 12-1-1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 213-22-2589 MD 88 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 XYes 2 ☐ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2555 Kirk Avenue 21218 S 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: 3 Widowed 4 □ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) n/a American Smelting Elementary/Secondary (0-12) 8th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Goldsborough Dorothy St. Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2555 Kirk Avenue Judith St. Rose-daughter Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Nat 12-1-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H la Balto, ) On 1101 E. North Avenue MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LSEASE Immediate Cause (Final OVONAVY disease or condition resulting in death) Due to (or as a consequence of): lav Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown art II. **Other significant conditions** contributing to death but not resulting in the underlying *c*ause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 100 1 ☐ Yes 2 **N**O 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ₫ No Hospi 1 ☐ Yes (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

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permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once.

event, the Medical Examiner must be notified at

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending pl for use as t ed by the pg a After this certificate has funeral director, page 2 n 24 hours after death.

e Funeral Director: Af letely filled in by the fur

Division of Vital Records, P.O. Box 68760.

I Examine Certificati

dica	
Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown
	Part II. Other signifi
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on: To	27. Manner of Death

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FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗆 Unknown

Natural

2 Accident 3 Suicide

4 Homicide

al: 1 Inpatient 2 □	BR/Outpatient	3 🗆 DC/	Other: 4	☐ Nursing H	ome	5 Residence	6 ☐Other
la. Date of Injury (Month, Day, Year)			c. Injury at Work? 1 □ Yes			Describe how inju	

5 ☐ Pending investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

28

29c. License number 0 4 1365

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) "3900 Loch Raven Boulgrathman

State Registrar

Medical

31. Date filed (Month, Day, 3

within 24 hor To the Fune completely f

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Rodney рм C. Scott 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto Towson Gilchrist Center 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Nonths Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F (Month, Day, Year) 60 218-74-7327 **Director** 49 MD Jsual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified MD N/A Baltimore 1 X Yes 2 □ No 0 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21206 23a Funeral 5493 Cedonia Avenue USA Examiner must 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ori 1 X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 Divorced Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event; the Mee once. College (1-4 or 5 th / a 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) Disabled Disabled 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John D. Scott Beulah Britton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5493 Cedonia Avenue Balto, MD 21206 Beulah Scott-Mother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place.
Crownsville Vet 11-30-09 Crownsville, MD 4 ☐ Donation 5 ☐ Sther (Specify) March East F/H 21. Signature of Funeral Service Lice 22. Name and Address of Facility Balto, 1101 E. North Avenue MD 21202 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Interval Between Onset an De th Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner longhs 4 nora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a constituence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Certificate: To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 341 30. Name and address of person who completed cause of death (Item 23a) (Type, Prip MQ. 6701 2 WJOH

State Registrar 31. Date filed (Month, Day, Year)

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** David O'Connor Smith November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 201 Lambert Ave. Carroll New Windsor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F Director 215-36-8124 70 15, 1938 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f s the Medical Examinar must be notified Director 1⊠Yes 2 No Maryland Carroll New Windsor 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? with 1 201 Lambert Ave. 21776 Pages 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examinat must U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1956–64 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**X** No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 truck driver milk transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be George Samuel Smith ပ Lela Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Y. Smith/ wife 201 Lambert Ave. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 12/2/2009 | nr. Linwood, MD 21. Signatur of Funeral Service Li 22. Name and Address of Facility Hartzler Funeral Home arine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician C LUNG ANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tyes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🙀 Residence 6 Other (Specify) 1□Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. spital or Attendi lours after death. neral Director; A 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

HEMAL ATHA NAGA 31. Date filed (Month, Day, Year) State NOV 3 0 2009

32 Registrar's Signature

700 A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NNA

Registrar

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D0061755

WESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1:30 PM<sub>M</sub> Lester J. Stanley, Sr. November 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3905 Darleigh Road Apt. Perry Hall Baltimore County 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Country) Virginia Months Davs Hours Min 83 Director 231-05-4332 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3905 Darleigh Road Apt. G 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 yr S Credit Manager Exxon Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Cornelius Stanley Jewell Ballard 19a. Informant's Name/Relationship (Type, Print)
Lester J. Stanley, Jr. - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Hollow Road Stewartstown, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Nov. 30,2009 BAltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Baltimore, Maryland 21214 1. Inc. 5305 Harford Rd. Tank 202 <u>eonar</u>d J Ruck 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 50phagen Onset and Death Physician/ disease or condition resulting in death) · Cars Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) Year 2 No 9 Unknown ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 155846 November 27, 2009

Registrar
DHMH 17 Rev 7/2009

State

7602

32. Registrar's Signature

Bel Air Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goodman, MD

31. Date filed (Month, Day, Year)

09-09131 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Phillip Samuel Slack State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2009 37885 Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 24, 2009 0000 hrs Philip Samuel Slack Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 935 Elton Avenue Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Months Day: Hours Mir Director 219-60-9166 1X M 2 57 12/04/1951 CountryMaryland Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Maryland Baltimore Dundalk must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 935 Elton Avenue U.S.A. 21224 Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married 2 X Married Yes 2 X No imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours afterment of Health and Montal Hygiene, tant: If item 27 is marked other than "natural", or other tranmaite event, the Medical Examine. Widowed If Yes, Give Year 2X No specify: Specify: White Divorced þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Mass Transit Elementary/Secondary (0-12) College (1-4 or 5+) 12 Subway Maintenance Administration 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ronald Slack Alma Hammerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Slack (wife) 935 Elton Avenue, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Date Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State partment o Bayview Crematory, Inc. 11/30/2009 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility Bruzdzinski Funeral Home, The Lituneral Service Licenses Old Eastern Avenue, Essex, Maryland 21221 Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line Between Onset and /Medical a. Contact Gunshot Wound of Head mmediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Sa X AMENDED reate has been signed by the attending physician page 2 should be detached for use as the burial UNPENDED 28e, per ME g899 1/11/10 TT Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. à Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medica 26.Place of Death (Check only one) funeral director, æ examiner? Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 2 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot self 1 FOUND: Natural after death. Pending Yes 2 V No Nov 24, 2009 0635 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 935 Elton Avenue , Baltimore, MD determined (Specify) Single Family Home Homicide

Hospital or Attending Physician: filled in by the

To the Funeral

Medical

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) BOS

ach 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

Death

Year

2 No

November 25, 2009

31. Date filed (Month, Day Year State Registrar

Victor Weedn MD JD

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 25, 2009 Dorothy H. Schoeberlein November 10:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Woods Nursing Center Rossville 8. Oate of Birth (Month, Day, Year) 03/22/1917 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2/204F 216-01-2900 92 Yrs Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show The Medical Examinar must be rectified at 1 Yes ZZNo Rosedale Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 6711 Kenwood Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2/CXNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify: Specify: Completed by White 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any lighty or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Uhl Catherine Purcell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 Sassafras Road, Baltimore, Maryland 21221 William Schoeberlein (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 12/01/2009 Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): the attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ঠ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🗍 Probably 4 🔊 Inknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 | Inpatient examiner? Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) ospital or Attending Phys hours after death. uneral Director: After this ly filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53462 MD cross of person who completed cause of death (Item 23a) (Type, Print) Jude Munesel, m.D. 30. Name and a

Registrar

DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

barks

Glen Burnie

Road

32. Registrar's Signature

MD

	1	For State Registrar	State of Marylan	•	rtment of F tificate of			giene leg. No. 7	nna	3788
Physician /Medical		1. Decedent's Name (First, Middle, Last)  Leonard H.			Scott		A to a formation of the con-		Year Zoeq	3. Time of Death 3: 30 AM
Examiner Funeral Director		4a. Facility Name (If not institution, give si  SINAL HOSPITAL  5. Social Security Number  214-30-7391  6. Sex		MORE		r Location of Death  (M & F  If Under 24 Hrs.  Hours Min.		4c. Con	unty of Death	olace (State or Foreign ntry) MD
how		Usual Residence of Decedent 10a. State 10b. County		y, Town or Loca	ation				1	0d. Inside City Limits
a or 28a-f st the notified		MD NA 10e. Street and Number 2513 West Baltim	oro Street	Balti	10f. Zip Code	1223		_	of What Cour	-
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinar mast be notified at once.  To Be Completed by Funeral Director			2. Was Decedent Ever in U.S Armed Forces? 1 Tyes 25 No If Yes, Give			dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14.	Race - Americ Black, White,	can Indian,
ygiene.  ter than "natural t, it e Medical E		15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give k life. D		during most of wor d)		Geor	of Business/In	dustry <b>l</b> man
Mental Hygi arked other atic event, iii To Be Co	ב	6th grade 17. Father's Name (First, Middle, Last) John Scott	na	Cons	tructi	on Worke 18. Mother's Nam Alda Ja	ne (First, Middle,			ion Co.
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artment of He ortant: if iten injury or oth		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Size aure of Funeral Service Licensee	Kir	ng Mem	ition (Name of atory or other place norial Name and Addre	Park 11	Date /24/09		ion - City or To	_
Departing in port any in one.	1	21. Six alure of Funeral Service Licensee  22. Name and Address of Facility arch F/H West 4300 Wabash Ave, Baltimore, Md 21215  23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be repeat failure. List only one cause on each line.  Approximate Interval Between								
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and so completely filled in by the funeral director, page 2 should be detached for use as the burial-transit so so so so so so so so so so so so so		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of the content of the c	BSTR1 UBSTR1 UBSTR1 UBSTR1 UBSTR1		PULMON	TEREM ARY DISE			
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n signed by	2	Part II. Other significant conditions cont URINARY TRACT IN								he cause of death?
certificate has been s irector, page 2 should		MULTIFOCAL ATA	RIAL TACKYC	ARDIA			24a. Was a autop perfor 1 □ Yes	sy		opsy findings available impletion of cause of
h. After this certif funeral directo	examiner?    Hospital: 1 Anpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)							fy)		
urs after death.  ral Director: After lled in by the funer.  Certification:		2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)				City or Town, State)				
hin 24 hou the Fune npletely fi		(Check only 2 Medical Examin one)	cian: To the best of my kno er: On the basis of examina and manner stated.		estigation, in my	opinion, death occu	urred at the time,	date and pla	ace, and due t	o the cause(s)
To t com		29b. Signature and title of certifier  NII Patd M.P.							d. Date signed (Month, Day, Year)  Sysmost 18, 2009	
		30. Name and address of person who con	MD. SIN	AN HOS		OF BAL	-TIMOR	Ē		
State Registrar		31. Date filed (Month, Day, Year)	32. Régistrar's Signa	ure A	anda!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37888 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2009 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner timore University of Maryland Medical 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1√2 M 2□ F Director N/A 18 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Martical Examinating at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD NA Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1555 Wadesworth Way 21239 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Y Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levern Singletary Linda Batchelor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Singletary-Mother 1555 Wadeworth Way, Baltimore, Md 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot
once. Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Memorial Park 11/24/09 Woodlawn, Md 21. Si mature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? \$ Completed 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Ves 2 No 2 🗆 No 1 □Yes 1 🖺 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 37889 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20, 2009 Month Physician 3:30 P M November Ellen Louise Hurson Steis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 31,1930 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Washington, D.C. 1 □ M 2 🔼 F 212-24-4067 79 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Bethesda Director Maryland Montgomery 1 ☐Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 20817 8202 Wahly Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates Specify Completed by 3 Widowed 4 Divorced "natural" Il Hygiene.
other than "natura 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I Ellen Gerrity 1 and 2 should by Health and Ments tem 27 is marked Daniel Hurson 27 is marked traumatic e 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Richard Steis/Husband 8202 Wahly Drive, Bethesda, Maryland 20817 Item 27 other t Baltimore, 20b. Place of Disposition (Name of Cametery, Grennetery of after place)
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition November 24 Pages 1 permit. Page Department c Important: If any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Silver Spring, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Pumphrey Funeral Home/ . 755/ Wisconsin Avenue 22. Name and Address of Facility Robert A. 1 Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 21. Signature of Funeral Service Lifense M01498 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minutes Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Atherosclerotic Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-tran Due to (or as a consequence of) 68760, ettending physician Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year requires that the de-5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No o 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by pe 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Diarrhea 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Dehydration 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 TNo Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To o filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 0 November 21, 2009 saveno /t D41507 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Nancy Davenport, 32. Registrar's Signature 31. Date filed (Month, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#6perFH, G897, 11/30/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 37890 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HARRY NOVEMBER 23, 2009 5:40 A LOUIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **8317** STEVENSON ROAD PIKESVILLE BALTIMORE 6. Sex 1 M 2 M 7 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Yrs. 045-14-6730 83 12-29-1925 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at Director 1 □ Yes 2 🕅 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8317 STEVENSON ROAD 21208 Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2 🕱 No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC HEALTH FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked LOUIS SAVITT FRIEDA **HOFFMAN** ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 8317 STEVENSON ROAD, PIKESVILLE, MD 21208 BELLA SAVITT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-24-2009 5 Other (Specify) RANDALLSTOWN, MD 4 Donation BETH EL MEM. PARK 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 critications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUVES /Medical Due to (o) as a consequence of): **Examiner** ears wen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CA Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a
To the Funeral Hospital 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
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Longo

CIN(e

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatu

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29c. License number D005194

Falls Red

29d. Date signed (Month, Day, Year)

November

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1:45PM 11 4c. County of Death Facility Name (If not institution, give street and number) Batimore Hebrew Geriatric Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/16/1922 Birthplace (State or Foreign Country) Social Security Number Days 1□M 2XF 216-16-0811 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County BREVARD COCOA BEACH 1 ☐ Yes 2 No 10e. Street and Number 750 N. ATLANTIC AVENUE, #601 10g. Citizen of What Country? 10f. Zip Code 32931 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry

Physician /Medical Examiner 1 - For State Registrar

10a. State

Director

Funeral

FL

Physician

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner burial-tra the ed by the attending detached for use as signed by t d be detach

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2AINo Specify:		Specify:	MHILE	
eted	15. Decedent's Ed (Specify only highest gra	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			king	6b. Kind of Business/Industry			
ompl	Elementary/Secondary (0-12)	College (1-4or 5+)	LEGAL SECRETARY				LAW		
To Be Completed by	17. Father's Name (First, Middle, Last) MAURICE MORGAN			18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY MOLOFSKY					
	19a. Informant's Name/Relationship (Type. Print) PAUL SACKS / SON 19b. Mailing Address (Street and Number or Rural Route Number, City of 418 DOE MEADOW DRIVE OWINGS MILL								
	20a. Method of Disposition  1	Removal from State ARL	lace of Displemetery, cre INGTOI	osition (Na ematory or AMUN	other place)		Location - City of		
	21. Signature of Funeral Service Licen		2	2. Name a		L LEVINSON ROAD PIKE		., INC. MD 21208	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not en	iter the mo	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		der	nortia			many years	
Sequentially list conditions, if any, leading to immediate causenter Underlying Cause (Disease or injury									
I Exam	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):							
dice		d	_						
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year		
d by Ph	Part II. Other significant conditions of	-	to the cause of death?						
mplete						24a. Was an autopsy performed	prior to death?	autopsy findings available completion of cause of	
ပ္ပ	25. Was case referred to medical	4.4			00 Plans of Par	1□ Yes 2 <b>∑</b>	No 1 □Ye	s 2 No	
o Be	25. Was case referred to medical examiner?  1  Yes 2 No							ecify)	
tion: T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	8b. Time of 28c. Injury at 28d. Describe how injury occurred					
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)			ctory, office 28f. Location (: City or Tot		Street and Number or Rural Route Number, wn, State)		
edical C	29a. Certifier (Check only one)  1ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Me	29b. Signature and title of certifier	Mouse CRNF	>		9c. License number RU70440		Date signed (Mor	1009 (Page 100)	
	30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)	Ive. Balti	more m	1D 213	215	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

3 0 2009

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ilya Simanovskix 4:00 PM 2000 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE RANDALLSTOWN SEASONS HOSPICE@NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/25/1930 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 78 BELARUS 213-35-1164 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Examinating in Intillad at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE Director 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6934 MILBROOK PARK DRIVE, #2A 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2X No WHITE Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR ELECTRICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KAPLAN LEV SIMANOVSKY HANNAH 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6934 MILBROOK PARK DRIVE, #2A BALTIMORE, MD 21215 MIRA SIMANOVSKAYA/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11/24/2009 BALTIMORE, MD Donation 5 □Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23 Fart 1. Enter the disease, from first lors that caused the with. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovascular Disease Atheroscu otic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatb? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 🗆 No 2 1 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one)

24 hours a within 2 To the i

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S Ray and a KE / MD - 25 Main 51 Kajapakse, MD 31. Date filed (Month, Day, 32. Registrar's Signature Kear MOV 3 n

29c. License number

D0057465

29d. Date signed (Month, Day, Year)

200 Reisterstrown, MD.21136 -

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 2009 **SHECTER** ROSALYN 6:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 725 MT. WILSON LANE, APT. #518 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 07/04/1914 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 □ F Months Days 95 NY 219-10-1243 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE, APT. #518 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify: WHITE Specify. 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JACOB** MARGARETEN LENA HERSCHENOV 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN SHECTER / SON 12 WHITEBRIDGE CT., BALTIMORE, MD. 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 11/27/2009 BALTIMORE, MD. f Fun I Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or compliant shock, or heart failure. List only wons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stroke Minutes disease or condition resulting in death) Due to (or as a consequence of) resterawe Years Cardiovascul Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical Examiner

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.

**Physician** 

/Medical

Examiner

10a, State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show dient Examinar must be notffled at

Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the Medical Examinar must

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner attending physician and for use as the burial-tran ed by the a detached f signed by t cate has been si page 2 should t this After

Physician/Medical þ Completed Be funeral within 24 hours after death To the Funeral Director:

Certification: To the filled in by

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Medical

29a. Certifiei one

1 Yes 2 1€ No

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

29c. License number D38675

BALTHONE

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 00

21202

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

MD

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MES HU LAM STRAUL

MO

32. Registrar's Signature

31. Date filed (Month, Day, Year) NOV 3 0 2009

State Registrar

Hospital or Attending

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month mtcr Day **Physician** 8:10 FM 26 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 12-20-1920 MD 212-12-4604 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip-Code 10g. Citizen of What Country? 725 MT. WILSON LANE, #303 21208 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after thent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 💢 No Specify: ρ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SYSCO FOOD MANAGER permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygie Important: If item 27 is marked other the any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS SALGANIK DORA DUSHMAN ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARC SALGANIK/SON 10386 ECLIPSE WAY, COLUMBIA, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of OHEB SHALOM MEM. PARK 11-27-2009 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signa e of Fundal Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only Onset and Death Immediate Cause (Final Latraceretra Physician disease or condition /Medical resulting in death) Duè to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Nes 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence မ 6 Other (Specify) 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 Tes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Hospita 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 3 0 2009

Vovember 26, 2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?  $\bigcap \bigcap Q$ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 7:15 A M Katherine M. Small 2009 Wend 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Future Care - Chesapeake Arnold Anne Arundel 8. Date of Birth (Month, Day, Year) 12/22/1916 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min. 220-09-4982 92 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 North Carolina Avenue 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Fitzgibbons Gertrude C. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert M. Small / Son 216 North Carolina Avenue, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🎇 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 11/28/2009 Baltimore, Maryland Qonation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>p</u>regnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 🗘 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending

1 ☐ Yes 2 ☐ No

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Loy Millerville MA

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event

**Physician** 

Examiner

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, II w Madical Examirer must be notified at

/Medical

Director

Funeral

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Completed

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MD

the attending physician as the

funeral director,

Examiner

investigation 6 Could not be determined

NOV 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a, Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical <u>Ş</u> Completed Be Certification: To 24 hours a Medical

Division of Vital Records, P.O. Box 68760 within 2

> State Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Veterans Huy

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year 2-15 AM 2009 NOV Danny Lee Smith, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE ST AGNES BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 XXM 2 □ F 232.42.2460 Nov 1, 1930 WVA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√√ No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Fairmount Rd. 21090

13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Clerk CSX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kermit Gould 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neva Smith 603 Fairmount Rd, Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Nov 25, 2009 | Glen Burnie, MD 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy, Glen Burnie, MD 21061 Gregory 23a. Part 1. Enter the diseas shock, or heart failure ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final PNEUMON UNKMOUN disease or condition resulting in death) Due to (or as a consequence of): FAILURE EXACERBATION UNIONSWA CONGES TIVE HEARI Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): DISE ATE UNILNOWN ANTERT SROWAR 7 resulting in death) Last Due to (or as a consequence of):

Examiner Box 68760. P.O. Records, or Attending Physician: The Vital ot Division

the burial-tran attending physician for use as the buria cate has been sign page 2 should be within 24 hours after deat To the Funeral Director:

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, its Modical Examinar must be notified at

7 Is marked other traumatic event, II

Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve once.

**Physician** 

/Medical

Pages 1

72 hours after

Baltimore, Maryland 21215-0036

dical		d. END STAGE R	ENAL DIST	ASE	UN KNOW A				
nysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year							
<u>-</u>	Part II. Other significant conditions of	o use contribute to the cause of death?							
ompleted by	PERIPHERA	2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
be	_ DIABETES	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No ✓ A							
E	HTPERIE								
å Re	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
<u> </u>	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
ation:	27. Manner of Death  1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju					
Certific	3 Suicide 6 Could not be 4 Homicide determined		factory, office	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>					
edicai	29a. Certifier  (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Š	29b. Signature and title of certifier	29c. License number	29d. Da	. Date signed (Month, Day, Year)					
		ATTENDING	00056948	No	V 23 2009				

PLACE

SLITE 3H BALTIMONE

Mr) 2/2:1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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**ORIGINAL** 

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day llaro 06 10an ovember 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Care Center Hopkins Bayview 6timore Johns Saltimore 8. Date of Birth (Month, Day, Year) Oct. 14,1934 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Hours 1 □ M 2 💢 F 219-30-6901 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 7381 Edsworth Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 X Married 1 ⊡Yes 2XXXVo If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Hammen Charles Bremer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9014 Moonstone Road Perry Hall, MD Patricia Simmons (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ¥X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 11/28/2009 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fur of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

**Examiner** 

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

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7 is marked other traumatic event, I

permit. Pages 1 and 2 shoul Department of Health and Mu Important: If Item 27 is mark any injury or other traumati once.

Director

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Completed

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transi

Medical

State Registrar 29b. Signature and title of certifie

B

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenough II min

Year)

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, ₹

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resulting in death)	Due to (or as a o nsequence of):							
Sequentially list conditions	uremia		d	ays				
Sequentially list conditions, in the cause. Enter Underlying	Due to or as a conse up ce of:			,				
Cause (Disease or injury that initiated events	renal tailure		d	ays				
resulting in death) Last	Due to (or as a consequence of):			4				
d								
IF FEMALE:	Co. If you collection of management							
23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of deliv								
1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			ay Year				
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?				
atrial Fibril	lation, chronic obstructive	2 1 X ves	2 No 3 Probat	oly 4 🗆 Unknown				
pulmonary d	isease respiratory failure		24h Marc autono	y findings available				
		= 24a. was an autopsy performed?	prior to comp	eletion of cause of				
	ypertension, malnutrition	1 □ Yes 2		□No				
25. Was case referred to medical examiner?		eath (Check only one)						
1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)					
27. Manner of Death  17 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how in	jury occurred					
2 ☐ Accident investigation	M 1 □Yes 2 □No							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural F	Route Number,				
	sician: To the best of my knowledge, death occurred at the time, date and planer: On the basis of examination and/or investigation, in my opinion, death or							
one)	and manner stated.							

29c. License number

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5505 Hopkins

29d. Date signed (Month, Day, Year)

2/1224

November 24, 2009

VIEW Civele

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2008 Hilda Tolbert 05 40 M 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A BALTIMORE
If Under 1 Year | If Under 24 Hrs. GOOD SAMARITAN HOSPITAL

5. Social Security Number | 6. Sex | 17. Age 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 8. Date of Birth (Month, Day, Year) **September 22, Funeral** Days Months Hours 1 □ M 2 🂢 F 1917 Maryland 217-20-7359 92 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience is used by rectified at Baltimore 1X Yes 2 □ No Maryland N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21206 3706 Southern Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 XNo þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Jackson John Tolbert 19a. Informant's Name/Relationship (Type. Print)
Paul W. Johnson/Son 19b. Maijing Address (Street and Number or Rural Route Number, City or Tawn Stay, Zip Code) 3706 Southern Avenue Baltimore Maryi and 21206 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jerusalem Lutheran Cem. 12/3/09 Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMBOLISM **Physician** Pul MONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ş 2 No RESPOTARY ACIDOSIS 3 Probably 4 Unknown SEVERG 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No COPD 24a. Was an autopsy performed? yes 2 2 No SEVERE DEHYDRATION 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

RES 000

**ORIGINAL** 

HOSPITAL, 6601 LOCH RAVEN BLVD, BALTIMORE MD

21239

State Registrar CHENGYU

31. Date filed (Month, Day,

XU

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUOD

SAMARITAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 37899 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Glenn North Der 4: 10PM ravis I will ler 209 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist HOSPICE Baltimore TOWSON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 213.04.9 39 Yrs **Director** 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f showny injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Be Completed by Funeral Director 139 Himore Randallstown 1 🗆 Yes 2 No MD 10e. Street and Numbe 10g. Citizen of What Country? Church Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Isual Displa technician 12th grade 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) lumer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22T84 Alison May 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11 29 Helping Hands Cemetery! burtland, 21. Signature of Funeral Service Licensee Vaugho C. Greene Farepal Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such ae cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death ☐ Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury 1 🔀 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) November 23 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Sigr

6701 N. Charles

			1 - State of Maryland / Department Certification	ent of Health a ate of Death	and Me	ntal Hyg	iene 20	09	37900
ı	Physici /Medic		Decedent's Name (First, Middle, Last)     Annie Laurie Taylor			Date of Deat Month 10V. 19	Day	Year	3. Time of Death 4:20 P M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. Cit  Franklin Woods Nursing Home	ty, Town, or Location o	of Death		4c. County Balt	of Death	e
	Funeral Director		5. Social Security Number  6. Sex 1 Month  7. Age (In yrs. last birthday) 1 Month  Yrs.	der 1 Year If Under is Days Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day, Dec. 15	Year) 1919	Cour	olace (State or Foreign ntry) qinia
	uryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location					1	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show f nuat be nutting a	Director		Zip Code		11	Og. Citizen of \	What Cour	1 ☐ Yes 2X No
	death w	Funerai I	9200 Franklin Square Drive  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. If Yes. st	21237 cedent of Hispanic Ori pecify Cuban, Mexican	gin? (Specif	ty Yes or No-		e · Americ	an Indian,
2-0036	ours after rral', or Its Examine	by	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	2 No Specify:	i, rueito Aii	Dari, Gic.,	Specify	ck, White, v: Wh	ite
1213-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show appringury or other traumatic event, it is Medical Examiner must be nutified at ADRG.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12 16a. Decedent's Us (Give kind of Ville DO NOT 12)  College (1-4or 5+) Aide	work done during mos	t of working		6b. Kind of Br		,
yiana z	ld be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) William Dagby Leebrick		er's Name (A	First, Middle, M .au			
Mary	id 2 shou Ith and M 27 Is mar traumat	-		ess (Street and Number			-		Code)
nore,	ages 1 an of Heal	1	20a. Method of Disposition  1 Natural 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Amherst Ceme	lame of r other place)	Dat 11/21	θ 2	20c. Location - Amherst	City or To	own, State
baitimor	permit. F Departme Importan any injur		21. Signature of Funeral Service Licensee T. Harman 22. Name	and Address of Facilit Srandview I	y Dri	skill	Funera]	Cha	pel, Inc.
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):			1000		este.	Approximate Interval Between Onset and Death
, 00,00	eath certificate be executed attending physician and for use as the burial-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
O. DOX	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours atterdeath.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 5 5 5 0 Other ( 9 ☐ Unknown					te of delive	ery Day Year
r (SDIOS	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.		23e. Did tob	_	ribute to th 3 □ Prob	ne cause of death?
חמפר וג	sician: The law re certificate has bei lirector, page 2 sho	Completed	Demonte, Hyg	pertensi'	04	24a. Was ar autops perform 1 Yes 2	/ jed?	Were auto prior to con death?	psy findings available mpletion of cause of
5	y Physician ar this certifi eral director	n: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 I  27. Manner of Death  28a. Date of Injury 28b. Time of	OOA Other:	rsing Home	Check only one 5  Reside d. Describe ho	nce 6 Oth		v)
DIVISION	To the Hospital or Attending Physician: The within 24 hours after dadh. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 4 Homicide (Month, Day Year) Injury M 28e. Place of Injury · At home, farm, street, factor building, etc. (Specify)	Work? 1 □ Yes 2 □ I ory, office	-	Location (Str City or Town	eet and Numb State)	er or Rura	I Route Number,
	the Hospit in 24 hour the Funera pletely filk	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurre medical Examiner: On the basis of examination and/or investigation and manner stated.	ed at the time, date and on, in my opinion, dea	d place, and th occurred	d due to the ca at the time, da	use(s) and ma te and place,	inner as st and due to	ated. the cause(s)
	To con	Σ	\$ \$\$ \psi_0.0.	9c. License number H355	93	-	d. Date signer		Day, Year)
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR TOHO (124 Mac C)  31. Date filed (Month, Day, Year)  32. pegisnar's Signature	H355 e Aug	Bo	alt/n	core	MI	2/22/
	Sta Registr	-	NOV 30 2009 James S. Jack	D					

ololon		State Registrar	-41		Cer	tificate of I	Death	2. Date of De		2009	3790
/sician		Decedent's Name <i>(First, Middle, La</i> Catherine Edna	Ulrich					Novembe		, 200°	8:45 P
ledical aminer	-	Facility Name (If not institution, gi				4b. City, Town, or	Location of Death			County of Death	
11111161		3306 Ryerson Cir	cle			Lansdow	me		E	Baltimore	
eral ctor		215-01-2786	Sex 7. Ag	e (In yrs. la 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 05-03-	th ly, Yea <i>r)</i> L918		lace (State or Foreig try) ginía
44	-	ual Residence of Decedent a. State 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limit
tor fee		MD Balt	imore		Laı	nsdowne					1 □Yes 2 □xN
Director	_	e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Coun	try?
ra le		3306 Ryerson Cir	cle				21227			USA	
the Medical Examiner must be notified at completed by Funeral Director	11	Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 1 If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba I □Yes 2 1 X No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, e Specify:	
t, the medical to		15. Decedent's E (Specify only highest gr	ducation ade completed)	Į.	16a. Deced	dent's Usual Occup	ation during most of working	ng	16b. Kir	nd of Business/Ind	dustry
d m	1	Elementary/Secondary (0-12)	College (1-4or	5+)	_					Shirt Co	mnany
္မ	17	. Father's Name (First, Middle, Las	t)		اد	eamstress	18. Mother's Name	(First, Middle	, Maiden :		Jiipany
To Be		Howard Davis	,					Helwi			
F	1-	9a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or Rura			r Town, State, Zip	Code)
r other traumatic event, II  To Be Cc		Sharon Walsh -	Daughter		3306	Ryerson (	Circle, La	ınsdown	e, Ma	aryland 2	21227
ury or omer	20	a. Method of Disposition	Removal from State	20b. Pl	ace of Dispo metery, cren	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City or To	wn, State
any injury or once.		4 □ Donation 5 □ Other (Special		Mead		ge Mem. I				ridge, M	
juce	2	. Signature of Funeral Service Lice	nsee (	7	22	. Name and Addre	ss of Facility Gar	y L. K	aufma	n Funera	al Home at
O		Mauc (3. 13	crawi	1.60			7250 Was	-		Elkridge	Approximate
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r			Due to (or as	a consequ		urenT4					
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EX	re	sulting in death) Last	Due to (or as	a consequ	ence of):						
edical			<b>d</b>								
/Medical Examin		FEMALE:	23c. If yes, outcome	of pregnal	ncv					204 Date of delive	D. W. L.
Physician/M	2	Bb. Was decedent pregnant in the past 12 months?	1 Live birth	2 🗀 Fetal	death 3[	Ectopic pregnanc	;y		1 *	23d. Date of deliv Month	Day Year
ysį		1 ☐ Yes 2 ∯2No 9 ☐ Unknown	9 🗆 Unknown								
by Pł	Pa	art II. Other significant conditions	contributing to death b	out not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to t	he cause of death?
	_	Mr & Homen	& BISEM	515				1 🗆	Yes 2[	□ No 3 □ Prol	pably 4 Unknov
	1							24a. Was		24b. Were auto	psy findings availab mpletion of cause of
plet	- 1							perfe 1 □ Yes	ormed?	death?	•
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Be Completed	2	5. Was case referred to medical examiner?	•				26. Place of Death	II (Oncor only			
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	2	examiner?  1  Yes 2  No  7. Manner of Death  1  Accident  3  Suicide 6  Could not determine  9a. Certifier (Check only 2  Medical Example)	28a. Date of Inj (Month, Di on De 28e. Place of In building, e Physician: To the best uniner: On the basis	jury - At holic. (Specify	28b. Time of Injury  me, farm, str	f 28c. Inju Wor M 1 = eet, factory, office	er: 4 Nursing Ho ry at k? lYes 2 No	28d. Describe  28f. Location ( City or To	Street an wn, State e cause(s, date and	y occurred  of Number or Run ) ) and manner as	al Route Number, stated. o the cause(s)
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pietery lilled in by the funeral director, edical Certification; To Be	2 2 2	examiner?  1 Yes 2 No  7. Manner of Death  1 Natural 5 Pending investigation  2 Naccident  3 Suicide 6 Could not determine  9a. Certifier (Check only one)  9b. Signature and title of certifier	28a. Date of Inj. (Month, Di. on be a second building, e)  28b. Place of In building, e)  28c. Place of In building, e)  28c. Place of In building, e)  28c. Place of In building, e)	irry jury - At ho tc. (Specify of my know of examinated.	28b. Time o Injury  me, farm, str  wledge, deation and/or in  23a) (Type,	f 28c. Inju Wor M 1 Ceet, factory, office h occurred at the to exestigation, in my 29c. Licens	er: 4 Nursing Ho ry at k? IYes 2 No  ime, date and place, opinion, death occur se number	28f. Location City or To	Street an wn, State e cause(s, date and	y occurred  of Number or Run  ) and manner as of place, and due to the signed (Month,	al Route Number, stated. o the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 5:15AM Vidal Maria ovember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2115 Statewood Road <u>Reisterstown</u> 6. Sex 1 ☐ M 2 🗓 F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year, Ct. 9. 1 South America 573-74-4534 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Cantanta Court, Apt. 326 21136 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 ¥ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Hispanic Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix Millan Carman Saavedra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Cantata Court, Apt. 326, Reisterstown, MD21136 Luis Vidal Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 11/28/09 Hampstead, MD

Physician/ Medical **Examiner** 

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate!

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Service Licensee	20	22. Name	and Address of Facility	11824 Re	istersto	wn Road
	24866	1	Eline	Funeral Home	Reisters	town, MD	21136
80.	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	4:00	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Opset and Death
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	Due to (or as a consequence of				**	
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 WNo 9 Unknown	c. If yes, outcome of pregnancy  1	3  Ectopio 5 Other (	c pregnancy (specify)		23d. Date of de Month	slivery Day Year
ompleted by Pl	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying	g cause given in Part I.		2 No 3 P	the cause of death?  by the cause of death?  crobably 4  Unknown  cropsy findings available  completion of cause of  completion of cause of
e	25. Was case referred to medical			26. Place of Death (Che		10 10	2 110
O	examiner? 1 ☐ Yes 2 No	spital:	patient 3 🗆	DOA Other:	ome 5   Residence	6 X Other (Spec	ity) HUSPICE
	27. Manner of D ath  1  Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	28a. Date of injury 28b. Tir		28c. Injury at work?  1 Yes 2 No	28d. Describe how inj		
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)			28f. Location (Street a City or Town, Sta	te)	
Medic	(Check 2 ☐ Medical Examiner only one) 3 ☐ Certifying Nurse F	an: To the best of my knowledge, der: On the basis of examination and/or Practioner: To the best of my knowledge.	investigation, in	n my opinion, death occurred a	at the time date and pla	ce and due to the	cause(s) and manner stated
	29b. Signature and title of certifier	" MOSGI	7) 29	9c. License number	29d. [	Date signed (Month	h, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Registrar's Signature

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) VECRU

31. Date filed (Month, Day, Year)

			1 - State Of Ma	•	Certificate of I			. No 2009	37903
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year 25, 2669	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	HOVEINDER	4c. County of Death	,,
and the second	LXummi		JOHNS HOPKINS BAYNIEW MEDI	LAL LENTE		more		N/A	
П	Funeral Director		5. Social Security Number 6. Sex 7. Ag  218-62-4387 1 ☑ M 2 ☐ F	ge (In yrs. last birtho Yr	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		
	D		Usual Residence of Decedent				reb. 10,		
	arylan show	ž	10a. State 10b. County  Marvland N/A	10c. City, Town o		altimore	City	1	0d. Inside City Limits 1 32Yes 2 □ No
	the M 28a-f	Director	Maryland N/A  10e. Street and Number		10f. Zip Code			. Citizen of What Cour	ntry?
	h with		7008 Gough Street			21224		United St	ates
	tems tems	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show "a livatical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 □Yes 2 □No	Specify:		Specify:	White
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occup Give kind of work done of	ation during most of work	ina 16	b. Kind of Business/In	dustry
121	filed within 72 Hygiene. other than "na' ent, Ine Medic	mple	Elementary/Secondary (0-12) 1 College (1-4or 5	5+)	ife. DO NOT use retired	)		Communicat	ions
	Hygi Hygi ther	Be Co	17. Father's Name (First, Middle, Last)		Engineer	18. Mother's Name	e (First, Middle, Ma	AT&T iden Surname)	
/lan	Mental Mental arked o	To B	Frank Vincer				Reggy Co	unts	
Maryland	nd 2 sho alth and I 27 is ma r traume		19a. Informant's Name/Relationship (Type. Print)  Jeffrey Michael Vincer (So	I .	Mailing Address <i>(Street)</i> 6018 Eurith			City or Town, State, Zip Maryland	21206
nore,	ages 1 a ent of Hea t: If Item y or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State		Disposition (Name of crematory or other place Service Co			c. Location - City or To	
Baltimore,	permit Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic et once.		□ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	7)	22. Name and Address Duda-Ruck	Funeral	Home of D	undalk, In	c.
	E02 # 0		23a. Part 1 Enter the discase, or complications that caused	d the death. Do no	7922 Wise			_	1222 Approximate
, F	Physician		shock, or heart failure. List only one cause on each li	ne.	SLEEP.			1	Interval Between Onset and Death
Act.	/Medical Examiner			a consequence of)					
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of)	:				
D,	xecute and I-trans	Examiner	triat iritiated events C	a consequence of)					
68/60,	rificate be executed ng physician and as the burial-transit	edical E	d						
	ertifica ling ph e as th	100	IF FEMALE:						(A. 1)
X ROX	death ce e attendii d for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deliver Month	ery Day Year
7. O	t the d by the ached	hysi	1   Yes 2   No 9   Unknown	it time of doubt	on onto (opoony) _				
ds, r	w requires that the death cer been signed by the attendin should be detached for use :	þ	Part II. Other significant conditions contributing to death b	ut not resulting in th	he underlying cause give	en in Part I.		cco use contribute to t 2 ☐ No 3 ☐ Prol	
Hecords	law requas beer 2 shoul	olete					24a. Was an	24b. Were auto	psy findings available
_	The la	Completed			-		autopsy performe 1 □ Yes 2		mpletion of cause of 2 ☐ No
VITAL	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:		Oth	ar.	h (Check only one)		
0	Phys er this eral dir	2	27. Manner of Death 28a. Date of Inju	ury 28b. Tin	ne of 28c. Injur	y at	ome 5 Residence 28d. Describe how	ce 6 Other (Special Control of the C	(y)
IVISION	Attending It death. ector: After by the funer	atio	1 Matural 5 Pending (Month, Da 2 Accident investigation	ıy, Year) İnju		(? Yes 2 □ No			
DIVIS	al or Atter after de: I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
;	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/					
1	Vithin To the compl	Me	29b. Signature and title of certifier		29c. Licens			. Date signed (Month,	
			1/1/2 Ce-		RES.	<del></del>		vember 2	
	8		30. Name and address of person who completed cause of a MARYARET LAVANA NGH HISSEY	leath (Item 23a) (Ty M.O. 49	ype, Print) 140 EASTER	N AVENU	E BALTIN	ORE, MARY	LAND 21224
ę	Sta Registr		31. Date filed (Month, Day, Year) 32 Tegistr	rar's Signature	P-00				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month am AJE mbir Medical Unknown 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 - F Months Hours Director December 26 ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 
Widowed 4 Divorced Specify. Year or Dates. other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) should be filed within and Mental Hygiene. Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ of Health and item 27 is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Burial 2 Cremation 3 Removal from State permit. Page 1 a
Department of I any injury or Donation 5 Other (Specify) 21. Signature of Funeral Syrvine Libensee mo 155. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Disease Paysician disease or condition resulting in death) rdiovascular Medical Due to (or as a consequence of) Examiner abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit rtension To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to or as a consequence of). resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Unknown Division of Vital Records, P.O. completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Monoclonal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Gammopathy autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c, License number November 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le 1000 E. Eager St. Baltimore, MD Z1202 31. Date filed (Month, Day, Year) NGV 3 0 2009 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARY MARGARET VAUGHN Physician/ NOVEMBER 20,2009 10:40 A M Medical <sup>4a.</sup> GILCHRIST HOSPICE CENTER 4c. County BAETIMORE Examiner 4b. City, Town ar Looption of Death 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) -14-1928 1 M 2 X Months Days Hours Min 216-20-2262 81 Yrs. Director MARYLAND Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10a. State 10c. City, Town or Location BALTIMORE ROSEDALE 1 🗌 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 7710 PHILADELPHIA ROAD U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. WHITE Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CHURCH HOME PURCHASING AGENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **GEORGE** SYKES DOROTHY (BOEGNER) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 7710 PHILADELPHIA ROAD ROSEDALE, MD RAYMOND VAUGHN/HUSBAND or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛣 Other (Specify) FNIMBMENT MORELAND MEMORIAL PARK 11-23-09 PARKVILLE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physiciani Jan Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be VAUCHV Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 mo ate has been signed by the atte page 2 should be detached for Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 욘 4 Nursing Home 5 Residence 6 NO Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES M) ( Marles towar mo 6701

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral 37906 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 0141 1 Ruth Delores Vernon 2009 Novembe 20 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Balti more N/A tuspita Hanes If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, You Oct 24, 7. Age (In yrs. last birthday) <sup>Year</sup>1931 Country) Indiana Days 578-40-4490 1 □ M 2 🗓 F 78 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 □Yes 2 XIo MD Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 USA 402 Roanoke Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐Yes 21 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Store Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vera Louise Calhoun Fred Orval Gott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17123 Old Baltimroe Road Olney, MD 20832 Steven Vernon(Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge MEmorial Park 11/24/09 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses L. Kaufman Funeral Home at MMP. Inc. Washington Blvd Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on eagy line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Atheroscleratic Cardiovascular Disease years Due to (or as a consequence of): Infarction Myocardial hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 1 ☐Yes 2 ☐No 1 Tes 2 🗆 No

**Physician** /Medical **Examiner** The law requires that the death certificate be executed

Department of Health ar Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

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death with

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "healest Examinat the retified at

Examiner burial-transi attending physician for use as the burial Physician/Medical s been signed by the should be detached à Completed After this certificate has funeral director, page 2 s Be Certification: To e Hospira. ... n 24 hours after death. he Funeral Director: Aff

ピハの 从より Division of Vital Records, P.O. Box 68760,

Hospital or Attending

within 2 the

23. Tras case relented to medical		20. I lace 01 Dec	illi (Orieck Orly Orie)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
200 Cartifica 1 Transituina Di	weiging. To the heat of my knowledge, death occ	urred at the time, date and place	e and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

D0058141

November 20, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Baltimore, MD 21229

State Registrar

Medical

31. Date filed (Month, Day, Year)

Jerard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09036 State of Maryland / Department of Health and Mental Hygiene Unk Unk 2009 37907 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month November 20, 2009 1649 hrs Medical Examiner <u>Jerard</u> Robert Welsh 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Edgewater 1200 Block Triton Beach Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** ForeignWashington, Country D.C. Months Hours Min. Director 577-90-4220 1<sub>X</sub> M 2 49 /06/1960 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10b. Count Yes 2 X No 23a or 28a-f show notified at once. Annapolis Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Maryland Anne Arundel rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States ö 21403 1215 Cross Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or items White etc. Armed Forces? Never Married 2 X Married 1X Yes If Yes, Give Year Yes 2 No specify: Specify: White Widowed Divorced event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 3 Real Estate Realtor is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Preston W. Welsh Gloria Neyland Neyland (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) 519 Ridge Road Annapolis, Maryland 21401 tant: If item 27 Eva A. Bowie/ Wife 20b. Place of Disposition (Name of cemetery, November 25. 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 2009 Metro Crematory, Inc Baltimore, Maryland Other Specify: 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line Death /Medical Drowning Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The Hospital or Attending Physician: The law requires that the death certificate be executed and cal sician a X UNPENDED 23a, 27, 28a-f, perm, E g898 12/30/09 TT Physician/Medi Box 68760, 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy phy the b 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. Yes 2 ✔ No 3 Probably 4 Unknown ≥ Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? this certificate has performed? ✓ Yes 2 No ✓ Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other-Hospital: 1 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred found in body After 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: of water with weights on his Yes 2X No Natura Director: d in by the f Pending Fd 11/20/09 4:44 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 B1k Triton Beach Rd. Edgewater, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. in by 3 X Suicide Could not be filled determined Beach body of water Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registra

**OCME 2006** 

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signatur

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WINTERSTEIN 3. Time of Death-Physician/ Month UGUST QL SM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Arundel Anne 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Date of Day, (Month, Day, <sup>Year)</sup> 19<u>26</u> Mary Land Director 219-18-9618 Nov Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Linthicum Heights 1 ☐ Yes 2 No Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 323 Regency Circle 21090 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 No Black, White, etc. 1 X Yes If Yes, Give 1 Never Married 2 Married þ 1941 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 ☐ Divorced Completed 1944 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Armco Steel Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည August Carl Winterstein, Sr. Julia Emry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Winterstein, Daughter 2108 Bay Drive Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State rutant; If it injury or o 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) tment Metro Crematory Inc. 11/25/09 Baltimore, Maryland . Sign nure / Funeral Service Licensee Name and Address of Facility Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 Alice Iser Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Physician/ nset and Death eon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death Month Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 은 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined building, etc. (Specify) within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of exa tion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) only one 29b. Signature and title of certific ed cause of death (Item 23a) (Type, Print Name and address of persors who complete NIM YENSE 01616 441 6 HWAY 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month Faye Marie Wade 12:30 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3344 Park Mill Road Frederick Adamstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours (Month, Day, Director 42 washington, D.C. 282-70-7708 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3344 Park M<u>ill Road</u> 21710 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 🙀 Married "natural", or Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Speech Pathologist Health Care permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, ti once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Betty Bechlen Rex Laverene Hoffmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3344 Park Mill Road, Adamstown, Maryland 21710 <u>Christopher L. Wade/ Husband</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 24. cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician. Malanant I

Due to (or a se onsequence of) Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence or; if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending i 24 hours after death.

E Funeral Director; Aileted filled in by the fu 2 🗆 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature nd title o 29c. License number D37018 29d. Date signed (Month, Day, Year) BL1509528 DEA 2009 no completed cause of death (Item 23a) (Type, Print) 30. Name and ddress of person v 600 N. Wolfe ST. Balt. MO Joh Hospit-P John MD 31. Date filed Month, Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 17:05 Norman Edward Wagner 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 16, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Hours Mary Land 86 Director 218-32-1352 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🎇 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 **USA** 4016 Deepwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. <sup>2</sup> □ № 1943 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 1946 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Traffic Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Erna Arnold Julius Murray Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Cedarcroft Road Baltimore, Maryland 21212 Deborah Shawen, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/30/09 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a con-equence of): disease or condition resulting in death) Medical Examiner le days Preumon Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury • LOVIDION OF THE PROPERTY OF THE PROPERTY OF THE GRAPH CERTIFICATE DE EXECUTED 24 hours after death.

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

• Funeral Director. After this certificate has been signed by the attending physician and letted filled in by the funeral director, page 2 should be detached for use as the bunal-transit monic that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438941 November 28,2009

State Registrar 31. Date filed (Month

gistrar's Signature

Union

memoria

Hospital Bathmoreins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Wallace Virginia Month Physician/ 2009 <del>Virgina E. Wallace</del> 1:15 A M November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year 1921 Country Waryland Days Hours July 27 1 M 2 XF 88 Director 213-52-1233 Usual Residence of Decedent 28a-f shov aţ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified 1 X Yes 2 □ No N/A Baltimore Maryland 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21206 USA 4727 Glenarm Avenue and Mental Hygiene. is marked other than "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Laura Rumbaugh Harvey Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health ; 4 Consett Court Nottingham, Maryland 21236 Department of Health Important: If item 27 Sherry Neal, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 11/27/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Sign ve of Funeral Service Licensee 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 Alice Iser any 54 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CEREBROVASCULAR ACCIDENT Medical resulting in death) . Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Exami physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2X No Year Month Day Pregnant at time of death 1 Yes 2X 9 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2**X** No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide
4 Homicide M within 24 hours after death

To the Funeral Director: A

completed filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and tile

31. Date filed (Month, Day,

JONES,

CRNP

30. Name and a

1:15 a.m.

2009

27,

NOVEMBER

VIRGINIA WALLACE

arks

2300 DULANEY VALLEY RD.

erson who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

29c. License number

TIMONIUM, MD 21093

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARTHA WILSON 5:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arudel Annapolis Ginger Cove If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year)
Months Days Hours Min. Feb. 3, 1904 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1□M 212 F South Dakota 578-40-9430 105 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arudel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9102 River Cresent Drive 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 🔀 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. 3 M Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Heath Powell Lela Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Tyeryar/ Daughter 313 Homeview Drive, Bridgewater, Virginia 22812 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 20. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 Metro Crematory, Inc. Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Marylan, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Heart Disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 76 mos Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Cher (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Mnknown

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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I Hygiene. other than "

12 should be filed w h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked c any jury or other traumatic ever 2016.

Director

Funeral

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Completed

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traumatic event, the Medical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

by Physician/Medical Examine burial-transit physician s the burial esn Be Completed page 2 s Certification; To

The law requires that the death certificate be executed

Box 68760.

P.O. I

Records,

of Vital

Division

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To the Hospital or Attending Physician:

within 24 hours after death, To the Funeral Director: A

filled in by

completely

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Z No

24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 De Ro 27. Manner of Death

28a. Date of Injury (Month, Day Year) investigation

28b. Time of Injury

28c. Injury at Work?

1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

person who completed cause of death (Item 23a) (Type. Defense Huy Amag. MD. 21401

KRIEGER, WID 31. Date filed (Month, Day, Year)

5 Pending

6 Could not be determined

32. Registrar's Signature

State Registrar

	311		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I			en2009	37914
	Physici	an	Decedent's Name (First, Middle, Last	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	DORIS LOUI		-			November		5:17 p M
	Examir	ier	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	
	Funeral		40 ROBINHOOD RD @ 5. Social Security Number 6. S		ST. (In yrs. last birthday		DE GRACE If Under 24 Hrs.	8. Date of Birth	HARFORD 9. Birth	place (State or Foreign
	Director		212-52-6915	□м 2ДДЕ	76 Yrs.	Months Days	Hours Min.	(Month, Day, ) AUG 4 19	(ear) Cou	ntry) YLAND
	pu »		Usuaf Residence of Decedent  10a. State 10b. County							
	Aaryla sho	5			10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2\times No
	28a-	Director	MARYLAND   HARFORE  10e. Street and Number	) CO	Н	AVRE DE C	GRACE	100	g. Citizen of What Cou	
	h with		40 ROBINHOOD RD	a 13 T.OCUST	r ST	210	78		U.S.A.	,
	iteme i	Funeral	11. Marital Status	12. Was Decedent E			Hispanic Origin? (Sp lan, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	
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21215-0036	72 hours after death with the Marylan "naturel", or iteme 23a or 28a-1 show idical Examinar must be notified a	ed b	3 XWidowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a, Dece	edent's Usual Occup	nation	16	Sb. Kind of Business/In	
215		Completed	(Specify only highest gra	de completed)  College (1-4or 5+	(Give	kind of work done DO NOT use retire	during most of work	ang	ou. Kind of Businessyn	loustry
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nd		Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ө (First, Middle, Ma	aiden Sumame)	
Maryland	should be nd Mental marked c	To	EDWARD MANN		401.14.19			NE MANNS		
Ma	d 2 th ar trau		19a. Informant's Name/Relationship (1				_		City or Town, State, Zi	
ē,	s t an f Heal item 2		Cheryl D. Paules/ 20a. Method of Disposition	Daughter	20b. Place of Disp	osition (Name of		-	ls Md 2 Oc. Location - City or T	
Ë	Pages ment of tant: If it		1 XX urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		BALTIMOR	matory or other pla E CEMETER	1	01/2009	BALTIMORE,	MARVIAND
Baltimore,	permit. Pa Departmen important: eny injury once.		21. Signature of Funeral Service Live	00	2	2. Name and Addre	ess of Facility			
_	89 = 9		( Way france)	1	3	21 S PHII	ADELPHIA	BLVD. AB	L HOME-HAR ERDEEN, MD	21001
			237. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to one cause on each line	he death. Do not en	ter the mode of dyll	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between
验	Physician		fmmediate Cause (Final disease or condition resulting in death)	a. 5	tage 4	(metus	tatie) (	Warian	Cancer	Onser and Death
1	/Medical Examiner		ſ	Due to (or as a	consequence of):					, 0
		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
X	ate be executed hysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
ò	be executed icien and burial-transit		resulting in death) Last		consequence of):					
87	ate b	dical		d						
9 ×	death certifica e attending ph id for use as th	/Med	IF FEMALE:	23c. ff yes, outcome o	f prognaga.					
Вох	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 2 Yes 2 2 No	1 Live birth 2	Fetaf death 3[	☐Ectopic pregnance	у		23d. Date of delive	ery Day Year
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Vital Records,	w require been sig should b							1 □ Yes	2 No 3 □ Pro	bably 4 □Unknown
ecc	e law n hes be je 2 sh	Completed						24a. Was an autopsy		opsy findings available ompletion of cause of
<u>=</u>	Thate are	S						performe	ed? death?	2□ No
Vite Vite	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.1		h (Check only one)		
ō	Phys rthis raldii	-: To	1 Yes 22 No 27. Manner of Death	I 🔲 Inpatieni		III OLI BON		ome 5 Residen	ce 6 Other (Spec	ify)
0	Attending r death. sctor: After by the fune	tlon	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	Wo	rk?  Yes 2□No	28d. Describe now	inquiry occurred	
Division	Atter	Ifica	3 Suicide 6 Could not be determined	28e. Pface of Injur	y - At home, farm, st				et and Number or Rui	ral Route Number,
ā	taior rs afte ai Dir	Certification:	4 [] Homicide	building, etc.	(Зреспу)			City or Town,	State)	
0	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	my knowledge, deal	th occurred at the time	me, date and place,	and due to the cau	se(s) and manner as	stated.
	thin 2 the 1 mplet	Medical	29b. Signature and title of certifier.	and manner state	9d.					
	Co. Co.		290. Signature and title of certified	11-		29c. Licens	54841	/	d. Date signed <i>Month</i>	Day, Year)
,	)		30. Name and add ss of person who	completed cause of do-	ath (Itam 23a) (Tues	The state of the s	, , , , , , , , , , , , , , , , , , , ,		///0	/ - /
7			Ashkan Bahrani		adelphia	*	imore,MD	21237		
į.	Sta	-	31. Date filed (Month, Day, Year)	32. Degistrar	's Signature					
1	Registr	ar	NOV 3 0 20	U9 Drews	J. 1. 10	arkel				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND ITEM#10b, perFH, G906, 8/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 4a. Facility Name (If no institution, give street and number) 26 2009 01: Movembor /Medical 4c. County of Death 4b. City. Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital N/A If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 XF MARYLAND Director 71 DEC. 31 1937 219-26-4255 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10h. Count 10c. City, Town or Location 28a-f show Harford Co 1 Yes ZXNo Directo notified MARYLAND JOPPA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō Examiner must be 23a U.S.A. 607 C. DEMBYTOWN RD. 21085 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 
Yes 2 
No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates: Specify: BLACK ş 3 XWidowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER PRIVATE 6th grade 18. Mother's Name (First, Middle, Maiden Surname) event, 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be JOHN CARTER MABLE CARTER မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 607 D Dembyton Rd., Joppa, Md., 21085 Duwaine White/Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-3-09 OWINGS MILLS, MARYLAND GARRISON FOREST permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. S. PHILA. BLVD, ABERDEEN, MARYLAND 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** pervolenna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pulmonary Hypertension sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 XNo 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à page 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 20 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 🗆 DOA မ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident investigation death. the \* Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

PO. of Vital Records. Division within 24 hours of To the Funeral I the Hospita

> State Registrar

Heather Parsons 31. Date filed (Month, Day, Year) 30

(check only one)

29b. Signature and title of certifier

32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arkel

29c. License number

29d. Date signed (Month, Day, Year)

Movember

600 North Wolfe St, Baltimore, MD, 21287

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 25, **Physician** 2009 4:00 A November Sherwood Weiss Lerov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 7500 Ives Lane If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F Director Oct. 24,1942 Maryland 212-42-4705 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐Yes 212 No Director Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21222 Funeral 7500 Ives Lane 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 📉 No Specify Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exan ponce. Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Products Sales Manager 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Miskimon ပ George Weiss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7500 Ives Lane Dundalk, Maryland Mrs. Loretta J. Weiss (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/28/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Chronic 10 years obstructive /Medical Due to (or as a consequence of): Examiner 5 years Interstitud Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an periormad. 1 □ Yes 2.□No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Invertal director, page 2 should be detached for use as the burlar-transit P.O. Box 68760, cate has been signed by page 2 should be detach Division of Vital Records,

show

or items 23a or 28a-f shown in items 23a or 28a-f shown in all be notified at

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State

Registrar

Medical 29b. Signature any title of certifier

29a. Certifier (Check only one)

and manner stated.

D.U.

29c. License number H0055992

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

21222

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah 6730 Gallo 1).0. Holabird

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

			State of Maryland / Departm  1 - State Registrar  State of Maryland / Departm  Certific	ent of Health and Me cate of Death		iene eg. No.	
i	Physici /Medic		Decedent's Name (First, Middle, Last)     SHARON WRIGHT-JOHNSON		2. Date of Deat Month	Day Year	7 159ath 7
**	Examin Funeral		4a. Facility Name (If not institution, give street and number)  JOHNS HOPKINS—BAYVIEW  5. Social Security Number  6. Sex 1 M 2 XF Mon	City, Town, or Location of Death  BALTIMORE  Inder 1 Year	3. Date of Birth (Month, Day,	4c. County of Death  9. Birthplace (Stat Country)	_
	Director		217-88-0209		UNE 8,		City Limits
	the Maryl 28a-f sho	Director	MD BALTIMORE DUNDALK  10e. Street and Number 10f.	. Zip Code	1	0g. Citizen of What Country?	es 2□No
	h with 23a or		6601 WOODS PARKWAY APT. 1C	21222		USA	
36	s after dear ", or items	by Funeral	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Mo 1 ☐ Yes	ecedent of Hispanic Origin? (Specispecify Cuban, Mexican, Puerto Ries 2 No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mcdral Exam has matter profiled in	Completed b	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind o	Usual Occupation f work done during most of working T use retired)	7	16b. Kind of Business/Industry	
nd 21;	be filed with tal Hygiene is other than event, the	Be Com		ISTRATOR 18. Mother's Name (i	First, Middle, I	US GOVERNMENT Maiden Surname)	
Maryland	should be and Mental s marked o	2	ROBERT D. THOMAS	LIZZIE I			
	and 2 sho ealth and n 27 is ma		, , , ,	OODS PARKWAY APT		OUNDALK, MD 2122	22
altimore,	Pages 1 and 3 nent of Health ant: If item 27 ary or other tr		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition cemetery, crematory  HOLLY HILL	i		20c. Location - City or Town, State  MIDDLE RIVER, M	
Balti	permit. Page Department Important: II any injury o				ES A. M	ORTON & SONS F.F. MORE, MD 21217	
المعمر	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	mode of dying, such as cardiac or		est, Approxin Interval E Onset ar	Between
	/Medical Examiner	Ţ.	Sequentially list conditions, if only, log life, to immediate.  Due to (or as a consequence of):  Due to (or as a consequence of):	S & S S			
- '09	ificate be executed g physician and is the burial-transit	al Examiner		Es Melli	ilus		
68760,		edical	d				
O. Box	The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as	Physician/M		pic pregnancy or (specify)		23d. Date of delivery Month Day	Year
rds, P.	w requires that to be by should be detact	è	Part II. Other significant conditions contributing to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the	ing cause given in Part I.		bacco use contribute to the cause of	of death?
Vital Records,	The law re ate has bee page 2 sho	Completed	WTH QV9		24a. Was a autops perform	sy prior to completion of	gs available of cause of
Vita V	sician: certific rector,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (			
Division of	To the Hospital or Attending Physician: The within 24 hous "fifter death.  To the Funeral Director. After this certificate h completely filled in by the funeral director, page	Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3  27. Manner Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M	28c. Injury at Work?		ence 6 □Other (Specify)  ow injury occurred	
Divisi	al or Atter s after dea il Director ed n by the	Sertifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office 28	3f. Location (S: City or Town	treet and Number or Rural Route N n, State)	umber,
1	he Hospit in 24 hours he Funera pletely fille	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur  Check only one)  Certifying Physician: To the best of my knowledge, death occur  Check only one)  Medical Examiner: On the basis of examination and/or investigated and manner stated.	rred at the time, date and place, ar ation, in my opinion, death occurred	nd due to the d d at the time, d	cause(s) and manner as stated. date and place, and due to the caus	e(s)
)	To t To ti	Σ	29b. Signature and title of certifier  Superior Truterius	29c. License number L D4810	5	29d. Date signed (Month, Day, Year	)
			30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)	576, Merri	T B	11/24/09 Stud. MD-2	7555
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Charles Edward Weast, Jr. November 19, 2009 2:35 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Chesapeake Shores Nursing Facility Lexington Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑** M 2□ F Days Hours Yrs. 220-05-3854 93 1/20/1916 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits St. Mary's Mechanicsville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20659 40142 Docker Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva May Darcy Charles Edward Weast, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dockser Drive, Mechanicsville, MD 20659 Christine Johnson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2009 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown S

**Physician** /Medical Examiner

**Physician** 

/Medical

MD

Director

Funeral

چ

Completed

Be

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic exercises.

physician and s the burial-transit as esn

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

Vade 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOWCKU

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, page 2 after death. Diractor: Aft

				24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No	24b. Were autopsy finding available prior to completion of cause of death?		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3□ DO/	h <i>(Check only one)</i> me 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>				
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		ic. Injury at Work?  1 □ Yes 2 □ No				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory,	office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,		
29a. Certifier (Check only one)	paictum: To the best of my kn. liner: On the basis of examina and manner stated.	władge, daeth occurred a ation and/or investigation, i	t the time, dete end place in my opinion, death occu	and due to the cause(s) and an red at the time, date and place,	and due to the cause(s)		
29b. Signature and the of certifier		29c.	License number	_	d (Month, Day, Year)		

12200 Annual his Rd A228 Clenn Sale M 20769

State Registrar

complately fillad in by within 24 hours a To the Funarai C

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

	Registrar				Cert				Reg. No.		
ician dical	1. Decedent's Name (F	el	1. 1		iams		ar Location of D	Mon	11-21-	- 2009 County of Death	3. Time of Death
niner al	4a. Facility Name (If no bar bor 5. Social Security Numb	ber   6. S	spital	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days		~	of Birth	9. Birth	hplace (State or Foreig
or	Usual Residence of Dec	438		10c. City	75 Yrs.	ation		8-1	17-1934		10d. Inside City Limit:
Director				Ba	4	ore			10.000	(141)	1 ■Yes 2 □ No
ral Dir	10e. Street and Number 2443 K	ermi	+ Co	ort		10f. Zip Code	30			ten of What Cou	untry ?
by Funeral I	3 ☐ Widowed 4 ☐		12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2 <b>™</b> No ⁄e		as Decedent of Yes, specify Cul □Yes 2 ☑ No	Hispanic Origin? ban Mexican, Pu Specify:	? (Specify Yes µerto Rican, et	or No- 1 c.)	4. Race - Amer Black, White Specify: 3/	
Completed	(Specify of Elementary/Secondary		ducation ade completed) College (1	-4or 5+)	Give k	O NOT use retire	during most of		16b. Kin	nd of Business/I	front
To Be Co	17. Father's Name (Firs	1 4	tines		7-011	5 011			iddle, Maiden S	,	<i>y r on r</i>
	Charlen	e Wi	(Type. Print)	Wife	2403	Kerm	t and Number of	+ Bo	alto.r.	nD 21	230
	20a. Method of Disposit  1 Burial 2 C  4 Donation 5 C  21. Signature of Funera	remation 3 Other (Specif	fy)	1 0	unt 1	Huburi		- 28-0	9 Ba	Ato.	
	23a. Part1. Enter the dishock, or heart fa	disease, or com	plications that ca	aused the death	5	151 Ba	Itimo	re Ma	HONA,	Pikel	Approximate Interval Between
Examiner	23a. Part 1. Enter the d	disease, or com allure. List only al	polications that coone cause on early a. Chr E Due to (	ach line.	Do not enter  Obstruence of):	151 Ba	Itimo	re Ma	HONA,	i Pike L Iseas	3x 1 to MD 2-12
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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Robert. 5:00 P M 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner andallstown Baltimore 2a.50n8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 212-56-3436 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evans and the matthe matter. 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No Baltimore 10g. Citizen of What Country? 10e Street and Number innamon Circle 12. Was Decedent Ever in U.S. Armed Forces?

1 Dres 2 \( \) No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hnician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) arolyn Bu AWNWOOD CIC. GWYNN DAK, MD Name of Date 200. Location - City of Town, State MD 21207 3altimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee . Greene funeral Vauga 728 Liberty Rd. Randallstom, WD 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or his straightful for the cause on each line. Immediate Cause (Final Disea se Physician End-Stare Hepatic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are unliked to the capture of the capture Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 \subseteq Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes within 24 hours after death.

To the Funeral Director: 2 Accident investigation 2 No filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number pakse M.D 120057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200, Keisterstown, MD. 21136 N. S. Rajapakse, M.D 25 Main St., Suite

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) NOV 3 0 2009

32. Registrar's Signature

**Physician** /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

23a or 28a-f

"natural", or Items 23a or

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27 is marked of traumatic ever

filed within 72 hours after death

Pages 1 and 2 should be 1 nent of Health and Mental

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

Examiner use detached for page 2 Certification: To

þ Completed Be

Medical

Physician/Medical

1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 ☐ Could not be 4 | Homicide

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number

SQUARE DR.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

21237

PARSHALL 31. Date filed (Month, Day, Year,

29a. Certifier

9105 FRANKLIN

Registrar DHMH 17 Rev 1/2001

State

To the Hospital or Attending Physician: filled in by the funeral within 24 hours after death To the Funeral Director;

this

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 18, **Physician** MAURICE WHITTINGTON 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Season's Hospice
5. Social Security Number 6. Sex Randallstown Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours **X**□ M 2□ F Davs Months 66 Director 577-56-2878 19 DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, Its Medical Eventinal must be rotified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Pikesville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 Funeral 7101 Pahls Farm Way U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. <u>Ş</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Secondary (0-12) College (1-4or 5+) Addiction Counselor 12th grade 2yrs Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Dunbar Hamilton Whittington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7101 Pahls Farm Way, Pikesville, Md 21208 Deanna Whittington-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 11/30/09 Owings Mills, Md 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate to se (Final disease or condition resulting in death)

a. 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, baltimore, Md 21215 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-trar physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the as attending nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) NORTHWOS Other: 4 Nursing Home 5 Residence October (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Natural Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 BUR no

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Registrar's Signature

			. 101	tate of Marylan				1ental Hy	giene			
			1 - State Registrar		Cer	tificate of Dea	ath		Reg. No.	000	379	23
п	Physicia	ın/	Decedent's Name (First, Middle, Last)  John Lee Willey					2. Date of De	eath er 24,	2 <u>/</u> 01/0	3. Time of Dea 4:40 A	ath
90	Medic Examir		4a. Facility Name (if not institution, give street	and number)		4b. City, Town, or Loc	cation of Death	Novemb		unty of Death		7 141
			Gilchrist Hospice			Towson				imore		
	Funeral Director		5. Social Security Number 6. Sex 1 X M	7. Age (In yrs. Ia 2 □ F 64	st birthday) Yrs.		Under 24 Hrs. ours Min.	8. Date of Bir Dec 19	th (), Year) () 944	g. Birth Cour <b>T'enne</b>		reign
	nd how at	<u>ا</u>	Usual Residence of Decedent  10a. State 10b. County	10c, City	, Town or Loc	ation				— Т	10d. Inside City Li	imits
	daryla 8a-f s tified	Director	MD Montgomery	Poole	esvill	e					1 ☐ Yes 2 <b>∑</b>	
	h the	<u>ة</u>	10e. Street and Number			10f. Zip Code			•	of What Cou	ntry?	
	ath wit ms 2% must	Funeral	16701 River Road	V- D- 1-15-110	I ao u	20837		i	USA			
ဖွ	within 72 hours after death with the Maryland iglene. er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at		1 Never Married 2 Married 1	Vas Decedent Ever in U.S µrmed Forces? X Yes 2 □ No	If	Vas Decedent of Hispar Yes, specify Cuban, M	lexican, Puerto			Race - Americ Black, White,	etc.	
21215-0036	urs af tural", al Exa	Completed by	l – – lif	Yes, Give ear or Dates. 1965—	68	☐ Yes 2 <b>X</b> No S <sub>i</sub>	pecify:		Spe	<sup>cify:</sup> Whit	:e	
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212	within giene. er tha , the N		Elementary/Seconday (0-12) Co	ollege (1-4 or 5+) <b>4</b>	Owner	TWO I use retired)			Real	Estate	/Finance	3
Maryland	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Willis Howard Willey	. Jr.			. Mother's Name		Maiden Sum	ame)		
ary	should be file h and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Pri		19b. Mailing	g Address (Street and I			er, City or Tow	n, State, Zip	Code)	
Σ	and 2 s Health s tem 27 i		Andrea Curme Willey/	wife	16701	River Road	d Poole	sville,	MD 20	837		
Baltimore,	- 4 <del>-</del> 2		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		meten/ crem	ition (Name of atory or other place) rney Crema	i	)ate <b>/25/09</b>		on - City or To		
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee	little MO1:	22. GO: 251 Ber	Name and Address of ing Home Ci verly L. He	remation	n Servi	ce P.	O. Box	784 MD 210	129
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	ns that caused the death.	. Do not enter	the mode of dying, su	ich as cardiac o	r respiratory an	rest,		Approximate Interval Between	
7	Physician/ Medical		Immediate Cause (Final disease or condition	Prostore	C	ancer					Onset and Death	
	Examiner		resulting in death)	Due to (or as a conseque	ence of):							
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p.	cuted	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c							$\perp$		
_	certificate be executed nding physician and use as the burial-transi	alE	resulting in death) Last	Due to (or as a conseque	ence of):							
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89 ×	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	yes, outcome of pregnan	death 3	Ectopic pregnancy				Date of deliv		
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P.	requires that the been signed by the should be detach	by P	Part II. Other significant conditions contribut	ting to death but not resul	Iting in the un	derlying cause given in	Part I.	23e. Did to	obacco use c	ontribute to t	ne cause of death	?
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Vital Records,	The law rate has bo	Completed						24a. Was autor	osy	lb. Were auto prior to co death?	psy findings availa mpletion of cause	able of
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Nta Nta	ysicia s certi directo	To Be	examiner?  1  Yes 2 No Hospita	al: 1  Inpatient 2  E	R/Outnatient	_ Other	of Death (Check		tonon e Mic	Other (Consider	hospic	
<del></del>	ng Ph fter thi ineral		27. Manner of Death 28:		8b. Time of injury	28c. Injury at work?		8d. Describe h			rospice.	
õ	ttendi death. tor: A the fu	Certificate:	2 Accident Investigation			M 1 ☐ Yes						
Division of	ital or A irs after ral Direc led in by		4 ☐ Homicide determined	e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stree	et, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On Certifying Nurse Pract	the basis of examination a	and/or investic	ation, in my opinion, de	ath occurred at	the time date a	nd place and	due to the car	ise(s) and manner	stated.
	Vith Voith		29b. Signature and title of certifier	-		29c. License num	ber		29d. Date sig	ned (Month, I	Day, Year)	a
	DDX1	ŀ	30. Name and address of person who complete	od course of death (the co	220/75 5	1/ )00	ربرر		IVOVTU	1500	24 200%	)
	DO,		30. Name and address of person who complete	ed cause of death (Item 2	OI N	nt) DSE	St :	BNJON	wo			
	Stat Registra	٧	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	bask	Ŋ						

			For State	State of Mar	yland				Mental Hy	gien	e 2000	0700
			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate of L	<i>Death</i>	1.5. (5	Reg. N	10. ZUUS	3192
	Physicia	ın/		11	T	Jaalam			2. Date of De		2 <sup>1</sup> 1, 2009	3. Time of Death
	Medic Examir		Genevie  4a. Facility Name (if not institution, give stre		ne v	Veeder	4b. City, Town, o	r Location of Dea		$\overline{}$	c. County of Death	
مرب	LXdiiii	ici	Montgomery General	•	1		ib. Oity, ioiiii, o	01ney			Montgome	
	Funeral	-	5. Social Security Number 6. Sex	a 1X1 = 1		t birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Min	S. 8. Date of Bir	th	9. Birt	nplace (State or Foreign intry) Trinidad Obago
	Director		579-70-6752	M 2 ELF   64	<del>/</del> +	Yrs.	months Suys	1,00.0	January	2, 1	.945 and 1	obago
	and show	٦	10a. State 10b. County	1	0c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryla 28a-f	rect	Maryland Montgom	nery		Silve	r Spring					1 ☐ Yes 2 🛣 No
	a or 2	al Di	10e. Street and Number	•			10f. Zip Code			-	Citizen of What Co	•
	th with ms 23 must	Funeral Director	1503 Foster Road				209				nited Sta	
<b>'</b>	or ite	y Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 X No</li> </ol>		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		14. Race - Amer Black, White	
93	rs afte iral", Exan	ed b	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	,	1	☐ Yes 2 🎇 No	Specify:			Specify: B1	ack
5-0	2 hou "natu edical	Completed by	15. Decedent's Educ (Specify only highest grade				ent's Usual Occup		orkina	16b.	Kind of Business I	ndustry
12	ithin 7 ene. • than he M	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)			NOT use retired) tered Nu			   He	althcare	
<u>0</u>	led will Hygin	Be	17. Father's Name (First, Middle, Last)			REGIS	cerea was		ame (First, Middle,	1		
/lar	d be f Menta arked artic ev	입	Dudley Alleyne					A1e	exandria	Ga	rcia	
lan.	shoul and I is ma		19a. Informant's Name/Relationship (Type,								or Town, State, Zip	
e, _	and 2 Health em 27 ther t		Roger F. Weeden, Ja 20a. Method of Disposition	r. / Son	001: 51:		ampbell	Lane, Ha		_	York 128	
nor	age 1 ent of lit. If it		1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State	cen	netery crem	atory or other place rematorium	Tnc Nover	nber 28,	!	Location - City or <sup>-</sup> ethesda	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signator of Fungral ervice Licensee	$\sim$	TIOTICE							
m	and De g	Ji i	Gregelette Barris	MC MC	1305	300 300	pert A. Pum West Mont	mphrey fun gomery Ave	eral Home/ enue, Rock	KOCK ville	cville, Inc e, Maryland	20850-3805
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused th	e death.	Do not ente	r the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
- 1	hysician/	0 1	Immediate Cause (Final disease or condition	Probab	10	mye	card	-0/13	Laret	75	77	Offset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	onsequer	nce off.			7			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	on sequer	ide oh:						
p	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.									
,	e exec sian ar urial-tı	a E	resulting in death) Last	Due to (or as a co	onsequer	nce of):						
9	ate be	edical	d.									
687	certific nding use as	M/M	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome of j							23d. Date of deli	ven/
Вох	eath c	icia	in the past 12 months? 1  Yes 2 No	1 Live Birth 2 4 Pregnant at tir			Ectopic pregnand Other (specify)	су			Month Month	Day Year
P.O.	t the c by the tache	Physician/Me	9 Unknown	9 Unknown								
<u>.                                    </u>	es tha signed be de	by	Part II. Other significant conditions contri	ibuting to death but i	not result	ing in the ur	nderlying cause giv	ven in Part I.				the cause of death?
rds	requir	etec										obably 4 Unknown
6C0	e law e has t ge 2 s	Completed by							24a. Was auto perfo	osv	prior to c	opsy findings available ompletion of cause of
<u> </u>	in; Th tificate or, pa		25. Was case referred to medical				26 Pl	ace of Death (Che		rmed? 2 A i	No 1 ☐ Yes	2 🗌 No
Zit Zit	ysicia lis cert direct	To B	examiner? 1 X Yes 2 \sum No	spital:	2. K EF	R/Outpatien	I Oak	or.		dence	6 ☐ Other (Specif	iv)
of	ing Pł		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	ear) 28	3b. Time of injury	28c. Injury work	y at	28d. Describe h			
ion	ttendi death stor; A r the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	One Disease Live	At hame			Yes 2 ☐ No				
Division of Vital Records,	al or A s after I Direc d in by		4 LJ Homicide determined	28e. Place of Injury building, etc. (S		e, iaim, sire	et, factory, office		City or Tow		nd Number or Rura e)	al Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physicia	an: To the best of my	knowled	ge, death o	ccured at the time	, date and place,	and due to the ca	use(s) a	and manner as stat	ed.
	the H hin 24 the Fi nplete	Mec	(Check only one) 3 Certifying Nurse P	ractioner: To the bes	nination a st of my k	na/or investi nowledge, d	eath occurred at the	e time, date and p	at the time, date a lace, and due to th	and plac e cause	e, and due to the ca (s) and manner as s	ause(s) and manner state tated.
_	Vitt Cor		29b. Signature and title of certifier			_	29c, License			29d. D	ate signed (Month,	
			30. Name and address of person who com			mk B	DO	1 mes	- 6 10 1	100	K D	2009
	20	l	30. Name and address of person who com			3a) (Type, Pi		1		1	200	1990

State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,9$ 

1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 16, 2009 November Marian B. Whelan 6:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery 8. Date of Birth (Month, Day, YApril 8, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 163-12-6408 91 1918 Pennsÿlvania Director Usual Residence of Decedent the Maryland r 28a-f show rotified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 X Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~r ? once. 9701 Veirs Drive 20850 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify. Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Secretary Private School 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ James Dean Porter Virginia Carrell McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David T. Whelan/Son 911 McMillen Court, Great Falls, Virginia 22066 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Rockville; Inc. 300 West Montgomery Avenue Maryland 20850 RU M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Parkinson's Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 🖾 No ed by the detached t 9 ☐ Unknown 9 Unknown certificate has been signed rector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Tes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 29a, Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one. and manner stated. within 2 To the I 29b. Signature 29d. Date signed (Month, Day, Year) November 18, 2009 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26033 Ridge Road, Damascus, Maryland 20872 Charles W. Karesh, M.D egistrar's Signatu State Registrar

DHMH 17 Rev 1/2001

09-09105	
Virginia Watts	

nia Watts		State of Maryland / D	epartment of Hea Certificate of Dea		giene Reg. N	200	9 379
Physicia	an/	1. Decedent's Name (First, Middle,Last)  Virginia E.	Watt		2. Date of Death Month Da November 23	3	3. Time of Death 0525 hrs
dical Exami		4a. Facility Name (if not institution, give street and number)		, Town, or Location of Death		4c. County of Death	
		Johns Hopkins Hospital	Balt	imore		n/a_	1 (0)
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 212-58-3768 1 M 2XF	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ths Days Hours Min.	8. Date of Birth (MDec. 15	M/DD/YYYY) 9. Birth Foreign Cour	
<b>b.</b>	t	Usual Residence of Decedent					10d. Inside City Limits
Maryland 28a-f show any 1 at once		147	c. City, Town or Location				1 Xes 2 No
rith the Maryland \$ 23a or 28a-f show notified at once	횼	MD n/a	Balti I 10f. 2	More	109.	Citizen of What Count	
e Mar or 28; fied at	Director	2201 Cecil Ave.		21218		USA	
vith th s 23a e notii		11. Marital Status 12. Was Decedent Eve	er in U.S. 13. Was Dece	dent of Hispanic Origin? ( Sp	ecify Yes or No-	14. Race - Americ	an Indian, Black,
r item	Funeral	1 Never Married 2 Married Armed Forces?		ecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	ack
after o	by F	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1Yes	2 X No specify:		Specify:	
hours natur Exami	ed	15. Decedent's Education (Specify only highest grade comple		al Occupation (Give kind of working life. DO NOT use reti		b. Kind of Business/In	dustry
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led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		
be fi	Be (	Floyd Jones, Sr.		Viro		L. Ful	
nould is man	은	19a. Informant's Name/Relationship (Type, Print )		ess (Street and Number or F			
alth and m 27 is aumati		Allan Nutter/Brother 1	in law 2201  20b. Place of Disposition (N	Cecil Ave.	Balto.	MC ZIZI  Oc. Location - City or	Town, State
permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State	crematory or other pla	ce)	i	·	-
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permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		21. Situature of Funeral Service Licensee		VIN B. SCRU 2 E. PRESTO	GGS_FUN	ERAL HOM	E
hysician	4	23a. Part I. Enter the disease, or complications that case of the	e death. Do not enter the mod	de of dying, such as cardiac of	or respiratory arrest	shock, or heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on each line Cocaine in	toxication				Death
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	ine	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	ence of):				
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be ey siciar	ledical		er ih g89/ l ,27,28a-f,per	mE, g898 12/9	9/09 TT	23d. Date of delivery	
<b>HOX 68/6</b> death certificate the attending phy ed for use as the b	Σ	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal dea	ath 3 Ectopic pregn			Day Year
th cert trendii	icia	past 12 months?  4 Pregnant at tim	ne of death 5 Other (\$	Specify)			
the a	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown	out not resulting in the underly	ving cause given in Part I	23e. Did toba	acco use contribute to	the cause of death?
ires that the signed by be detach	by F	Part II. Other significant conditions contributing to death b	at not resulting in the broom	ying cause given in a circu	1 Yes		pably 4 🗸 Unknown
duires en sig uld be		· · · · · · · · · · · · · · · · · · ·			24a. Was an		itopsy findings availab
LIVISION OF VICAL RECORDS, tall or Attending Physician: The law requiring a stare death.  a) Director: After this certificate has been seled in by the funeral director, page 2 should!	흩	<u> </u>			autopsy perform	ed? death?	completion of cause of
VICAL REC ysician: The l his certificate l director, page	Completed	1		26.Place of Death (Check	1 Yes 2	No 1 <b>✓</b> Y	es 2 No
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Of VI ing Physi After this uneral dir	<u>P</u>	27 Manner of Death 28a, Date of Injury		28c. Injury at Work?		w injury occurred	
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spital or spital or sours afte neral Dir filled in	E F	Suicide 6 ACould not be determined (Specify) Res	idence		2201 Cec	il Ave. Ba	ltimore, M
DIVISION  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Sal C	29a Certifier	knowledge, death occurred a	t the time, date and place, ar	d due to the cause	(s) and manner as sta	ted. ne cause(s)
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of exami and manner stated.	nation and/or investigation, in			29d. Date signed (Mo	
	Σ	29b. Signature and title of certifier	_	29c. License number O.C.M.E.		November 23, 2	
		My Brasse GMY >	4.49 .00	J.J.IVI.E.			
K		30. Name and address of person who completed cause of dea Melissa Brassell, MD Assistant Medical E		Street, Baltimore, MI	21201		
V	State	Loo E Contracto	Signature				
Regi		4	S. park				
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Maurice Weaks		I- For State	Sta	ate of	Maryla	nd / [	-	ment of <i>icate of</i>	Health ai	nd Mer	ntal Hy	_	eg. No.	21	ากจ	3 :	3792
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Funeral		5. Social Security N		6. Sex		7. Age (I	n yrs. last	birthday)	If Under 1 Ye			8. Date of Bir	th (MM/	OD/YYYY)	9. Birth Cou		tate or Foreign
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any .	ŀ	Usual Residence o 10a. State	10b. County			10	c. City, To	wn or Locat	on						Т	10d. Insi	de City Limits
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Baltimore, permit. Pages I an Department of He Important: If ite		1 XXBurial 2		3 XX	Removal fro	m State	cren	natory or oth				Date		ocation - (	•		ate
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Box 6876( e death certificate the attending phy ed for use as the b	Clar	past 12 months	?	4	=-		e of death	- =	al death 3 er (Specify)	Ectopi	c pregnanc	су		Month	Da	у	Year
the deal y the all shed for	Physician/M	1 Yes 2 N			Unknov		t not rocul	ting in the u	adarlying agus	given in Br	net I	23e. Did to	baccou	isa santrih	uto to th	20 001100	of dooth?
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tal Records cian: The law requi certificate has been ector, page 2 should	Completed				-				_			perfor	med?	de	ath? ✔ Yes	•	2 No
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of Viliog Physic	의	1 ✓ Yes : 27. Manner of Deat	2 No	11035	28a. Date o			Outpatient  b. Time of Ir		Other4 ury at Work		Home 5 8d. Describe h	Resider		Other:		
OD C codiog ath. or: Aff		1 Natural	5 Pendi		(Month, I	Day,Year)		d 11:3	· I .	Yes 2	- 1	nk	iow injui	ry oddania	•		
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ospital hours hours y filled	5	4 Homicide	deterr		(Specify)	_					B	<u>Baltimo</u>	re,	MD			
Division of Vital Rec To the Hospital or Atteoding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, page	<u> </u>	(Check only	Medical Exam	nigrep.On	the basis of tmanner sta	examina	owledge, o ation and/o	r investigati	ed at the time, on, in my opinion	date and pla n, death oc	ace, and du curred at t	ue to the caus he time, date a	e(s) and and plac	d manner a ce, and du	s stated to the	i. cause(s)	)
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	(	30. Name and addr Mary G. R			pleted cause y Chief M				Penn Stree	t, Baltim	ore, MD	21201					
Sta		31. Date filed (Mont	h, Day, Year)		32. Reg	istrar's S	ignature	Δ.		<u> </u>							
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To the Hospita within 24 hours	Division or Vital Records, P.O. Box 68760,	il or Attending Physician: The law requires that the death certificate be executed after death.
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		For State	State of Mar	-	•		Mental Hy	giene Reg. No 2009	37928
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Physici	an	1/10LET	MARIE	- 76	= PP		Month	_Day Year	
/Medic Examin		4a. Facility Name (If not institution, give		26		or Location of Deat	1/VUU	30 200° 4c. County of De	
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land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
Mary -f she	tor	MO CARR	LOLL !	WEST	TMINSTI	ER			1XYes 2□No
h the or 28a o notii	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mentall Hygiene. Health and Mentall Hygiene. Health and Mentall Hygiene.  The Z7 Is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	<u>a</u>	1234 WASI	HINGTON	1 ROAX	211	57		USI	4
er dea tems ier mi	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 6:02 PM FRANK G. ZIZLAVSKY NOV. 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF HARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Hours 1 X M 2 □ F Illinois December 3,1941 Director 344-36-8071 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Rockville Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 Carl Street 20851 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ann of Health and Mental Hygiene. ante If item 27 is marked other than "natural", or ite any or other tranumatic event, the Medical Examinary ny or other traumatic event, the Medical Examina 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify ₽ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrator Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Zizlavsky Jeanne Majkrzak ၉ permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is mar any Injury or other traumat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne A. Zizlavsky/Wife 308 Carl Street, Rockville, Maryland 20851 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date November 30, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Crematoriúm, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland 22. Name and Address of Facility Robert A. Rockville Inc. 300 West Rockville; Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Lieshses Rockville Rockville; M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA 3 WEEKS /Medical Due to (or as a consequence of): Examiner 2 YEARS Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IDIOPATHIC PULHONARY FIBRUSIS Examiner Due to for as a consequence offiand the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **H**O 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Division

with the Maryland

21215-0036

Baltimore, Maryland

been signed by the attending p should be detached for use as cate has l After this certificate To the Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral I

completely filled

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1346475191

NOV. 24, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARAH GOLDSERG

22 S. GREENE ST., BALTIMORE MD ZIZOI

31. Date filed (Month, Day, Year)

29a. Certifier

32. Pigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Day 24, 2009 Physician/ Theresa Zabkowski 8:45A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Care Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2X□ F Months Jan 28, 1920 Maryland Director 89 216-03-5691 Usual Residence of Decedent ä 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Md. Baltimore Parkville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 7840 Oakdale Avenue 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ☐xWidowed 4 ☐ Divorced White Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) 8th College (1-4 or 5+) Owner/Operator Liquor Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glinski Stanislaus Anastasia Health and № 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $P.0.Box\ 140\ Nanticoke,\ Maryland\ 21840$ Ben J. Zabkowski (son) Page 1 and 2 Department of Hea Important: If item Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cem. 20c. Location - City or Town, State November any injury or 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 27.2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 2000c 201 Dundalk Avenue Baltimore. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ erebrovascular disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate tauts. Error Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav Year 1 Yes 2 Unknown o. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure Records, 2No 3 Probably 4 Unknown 1 Ves 24b. Were autopsy findings available prior to completion of cause of death? Coronay 24a Was an has Hospital or Attending Physician: The law performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 A Other (Specify) Hospi Cu Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation withir 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 후 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, CRNP R149194 November 24. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Grant Towson, MD

State

Registrar

31. Date filed (Month, Day, Year)

NOV 3 0 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician John Joseph Allen <u>1:</u>30p <sup>M</sup> 2009 /Medical November 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Birthplace (State or Foreign Country)
 New York 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/14/1930 If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 107-22-8575 1 M 2 □ F Director 78 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location at o 1 □Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Manent of Health and Mental Hygiene. Baltimore Upperco M Directo ral", or items 23a or 28a-f Exerciper roust be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21155 U.S.A. 16338 Trenton Road Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ▼ Yes 2 □ No 1948If Yes, Give 1052 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2√∑No Specify: white 1952 3 ☐ Widowed 4 ☐ Divorced "natural" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maryland State Police Elementary/Secondary (0-12) College (1-4or 5+) Truck Weight 12 Service supervisor III Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Higgins is marked Arthur J. Allen ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 16338 Trenton Road, Upperco, Md. 21155 Linda Baird Allen, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/2009 | Hampstead, Md. Grace U.M. Cemetery M00742. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Jicensee 934 S. Main Street, Hampstead, Md. 21074 Lemmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2 No certificate has been signed by the rector, page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: #
y filled in by the fr 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1) Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi marmer stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 leted cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and add

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician November 08 2009 M q 00:8 Anna Belle Aldridge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Golden Living Center Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F Jan 30 1918 91 PA Director 213-05-1249 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the the state of the contract and traumatic event, the the state of the contract and the state of the contract and the state of the contract and the state of the contract and the state of 1 ☐ Yes 2 ☑ No Director Westminster Carroll MD 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21157 Carroll 1234 Washington Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ X O If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 □No Specify Specify: \$ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Assembly Technician MD Cup Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alice Shaffer Albert Henry Snyder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trauonce. 1922 Frizzellburg Road Westminster, MD Darrell Aldridge/son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/12/2009 | Westminster, MD Meadow Branch Cem 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Se Printed Tunerfally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part I. Entertibe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform certificate 2 No 1 □Yes director, 25. Was case referred to medical 26. Place of Death (Check onl. one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 1 0

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

		For State Registrar	Otate of Maryla		rtificate of			Reg. No.	09 3/93
Physici /Medic		1. Decedent's Name (First, Middle, La  MARGARE)		ABRAHA	AMS		2. Date of Dea Month Novembe	Day	Year 3. Time of Death 5:00 A M
Examin		4a. Facility Name (If not institution, given Frederick Memory)	re street and number)			r Location of Death	1	4c. County of	of Death erick
Funeral Director		5. Social Security Number 6. S 218–40–0382		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jun 25,	1935	9. Birthplace (State or Foreign Country) Maryland
If it is a factor of the many	Director	Usual Residence of Decedent  10a. State  Maryland  Freder		City, Town or Lo		Emmitsbur		10g. Citizen of W	10d. Inside City Limits 1 □ Yes 2 ▼No
tth with t 23a or 3	ral Dir	8744 Crystal Four	itain Road		Tot. Zip Code	21727		USA	•
rurs after dearal", or Items	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Ye's or No- o Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. : white
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Traumatte event, the Medical Evantment one notified at once.	Be Completed	15. Decedent's E (Specify only highest grants) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired emaker	pation during most of wor d)	king	16b. Kind of Bu	
should be filed v and Mental Hygie s marked other t numatic event, th	To Be C	17. Father's Name (First, Middle, Last William D. Curtis					ne (First, Middle,	Maiden Surname	e)
and 2 shoul ealth and M n 27 is mar ner traumat	ř	19a. Informant's Name/Relationship (Grant W. Abrahams			ng Address <i>(Street</i> <b>Crystal</b>				State, Zip Code)
rmit. Pages 1 ar partment of Hea portant: If item 1 y Injury or other		20a. Method of Disposition  1   Magazial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci.	Themoval nom State	Place of Dispo cemetery, crei mitsbur	osition (Name of matory or other place g Memoria	al 11/1	Date 0/2009		City or Town, State
permit. Departr Importa any Inju		21. Signature of Funeral Service Lice	Sulta	22	2. Name and Address 210 W Mai	n St, Emn	vers-Durk nitsburg	ooraw Fu , MD 217	neral Home 27
Physician /Medical Examiner  By Striam and as the parial-transit a	cal Examiner	23a. Part 1 Enter the disease, or come herek, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the de one cause on each line.  a. Due to (or as e consection to consection)  Due to (or as a consection)  Due to (or as a consection)	equence of):	Bowel	ng, such as cardiad		rest,	Approximate Interval Between Onset and Death
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uires that in signed by	by	Part II. Other significant conditions	0.200		nderlying cause giv	ven in Part I.			ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Completed						24a. Was a autop perfor 1 🗆 Yes	an 24b. V ssy p rmed? d	Nere autopsy findings available prior to completion of cause of death? □Yes 2□No
hyslcia: his certi I directo	To Be	25. Was case referred to medical examiner?  1 Yes 24 No	Hospital: 12 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	or:	ath <i>(Check only oi</i> Iome 5 ☐ Resid		er (Specify)
anding Plath.	ation:	27. Manner of Death Natural 5 Pending 2 Accident investigatio		28b. Time o Injury	Wor	ry at k? Yes 2 □ No	28d. Describe h	now injury occurre	ed
tal or Atter safter de al Directe led in by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	er or Rural Route Number,
e Hospi 24 hou e Funer fetely fill	Medical		hysician: To the best of my k miner: On the basis of exami and manner stated.						
To the within To the Comp	Me	29b. Signature and title of certifier	*		29c. Licens	Se number 51610		29d. Date signed	(Month, Day, Year)
n45		30. Name and address of person who			Print)		0515 a	1 1	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature				- (	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 37934 State of Maryland / Department of Health and Mental Hygiene

	1. For State Registrar	Certificate of Death	Re	g. No.
Physician Medical Examine			2. Date of Death Month November	Day Year
Barre .	4a. Facility Name (if not institution, give street and number 501 Booth Street	per) 4b. City, Town, or Elkton	Location of Death	4c. County of Death Cecil
Funeral Director	5. Social Security Number 6. Sex 7. 222-50-5220 1 M 2 F	Age (In yrs. last birthday)  49  Yrs.  Hr Under 1 Yea  Months Day:		h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Delaware
н апу	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
Varyland 28a-f show any d at once. Pector	Maryland Cecil  10e. Street and Number	E1kton		1 X Yes 2 No
th the Maryland 13a or 28a-f sh notified at once	501 Booth St.	219	21	USA
Baltimore, MD 21215-0036  semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a no 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	es? 2 X No 1 Yes 2 X No		White, etc.  Specify: White
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam	15. Decedent's Education (Specify only highest grade  Elementary/Secondary (0-12) College (1-4  8	during most of working life		16b. Kind of Business/Industry  Heavy Equipment
215-0036 be filed within 7 mal Hygiene. rked other than rent, the Medica Be Comple	17. Father's Name (First, Middle, Last)  Gerald Boyd	,	18.Mother's Name (First, Middle, M Eunice Sparks	laiden Surname)
MD 21 od 2 should 1 ilth and Mer m 27 is mar aumatic ev	19a. Informant's Name/Relationship (Type, Print)  Ann Marie Boyd/Wife	501 Booth St	., Elkton, MD 2	ber, City or Town, State, Zip Code)
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Orpartment of Health and Mental Hygener, Important: If item 27 is marked other tinjury or other traumatic event, the Med To Be Comi	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from  4 Donation 5 Other Specify:	State 20b. Place of Disposition (Name of cer crematory or other place)  R.T. Foard Funera	11-11-2009	20c. Location - City or Town, State  Rising Sun, Maryland
Baltimo permit. Page Department Important: injury or ot	21. Signature of Funeral Service Licensee	22. Name and Address R.T. Foard	of Facility	
Physician /Medical xaminer		sed the death. Do not enter the mode of dying, ic Cardiovascular Disease	such as cardiac or respiratory arre	Approximate Interval Between Onset and Death
	or condition resulting in death)  Due to (or as a condition sequentially list conditions,	· · · · · · · · · · · · · · · · · · ·		
ted Insit Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a co			
760, icate be executed physician and the burial - transit	d.  UNPENDED AMENDED			
760, ficate be execuing a physician and the burial - tra	IF FEMALE: 23c. If yes, out	come of pregnancy		23d Date of delivery
). Box 687: the death certification by the attending ached for use as I Physician.		t at time of 5 Other (Specify)	Ectopic pregnancy	Month Day Year
s, P.O. Bo ires that the de signed by the dibe detached f	Part II. Other significant conditions contributing to d Chronic Obstructive Pulmonary Disease			bacco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown
cords aw requ has been 2 should			24a. Was a autops perforr	sy prior to completion of cause of
Vital Recysician: The list certificate lifector, page	25. Was case referred to medical examiner?		of Death (Check only one)  Other  Nursing Home 5 F	Residence 6 🗸 Other: Scene
nd of Vit ading Physic th. : After this e funeral dire	27 Manner of Dooth	Injury 28b. Time of Injury 28c. Injury		ow injury occurred
Division or To the Hospital or Attending within 24 bours after death. To the Funeral Director: Afte completely filled in by the fune edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	of Injury - At home, farm, street, factory, office b	uilding, etc. 28f. Location (Stor Town, Stor	treet and Number or Rural Route Number, City ate)
To the Hosp within 24 hou To the Funct completely fi		f my knowledge, death occurred at the time, da examination and/or investigation, in my opinion ed.		
	29b. Signature and title of coffifier  Gulvelell	29c. Licens O.C.I		29d. Date signed (Month, Day, Year) November 10, 2009
5	30. Name and address of person who completed cause Laron Locke MD. Assistant Medical B		nore, MD 21201	
State Registra		strar's Signature		
DHMH 17 Rev 1/2001	MAA T - FOOD CENT	OPIGINAL		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland				lealth a Death	and Me	ental Hy	giene Reg. No. (	009	37935	5
	Physici	ian	Decedent's Name (First, Middle								2. Date of De		Year	3. Time of Death	
	/Medi	cal	4a. Facility Name (If not institution	George	R.	Воус		Tour	r Location o	of Doorth	11	11		10:30 P	M
	Examir	ner	Calvert Manor Nurs						s Sun				ecil		
	Funeral		5. Social Security Number	No.	e (In yrs. la	st birthday)	If Under Months		If Under a		8. Date of Bir (Month, Da	th		place (State or Foreigntry)	gn
	Director		188-07-4541 Usual Residence of Decedent	124M 2LIF	92	Yrs.	Wioriais	Days	110010		3-14-			PA	
	yland tow		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limit	s
	e-feh	ctor	MD C	ecil		Risi	ing S	Sun						1 ☐ Yes 2√∑N	0
	with the	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cour	ntry?	
	eath v		1881 Telegr	aph Road	Suprin 11 S	10.1		911		in 2 /Cana	it. Vac ar Na	US.	A Race - Americ	on Indian	
တ	offer d	Funeral	1 ☐ Never Married 2X Mar	Armed Forces?		13.1				, Puerto R	cify Yes or No lican, etc.)		Black, White,	etc.	
93	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	ried 1 Xes 2 1 If Yes, Give Year or Dates:	942-46		1 ☐ Yes 2	2 X No	Specify:			Sp	ecity: Whi	ite	
15-(	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or itema 23a or 28e-f show ant, the Medical Examinar must be molitied at	Completed		t's Education st grade completed)		16a. Deced	dent's Usua kind of wor	k done	ation during most f)	of workin	g	16b. Kind	of Business/In	dustry	
212	l withii jene. r than	ф	Elementary/Secondary (0-12)	College (1-4or 5	5+)				, inee			Gove	rnment	- -	
P.	al Hyg	Bec	17. Father's Name (First, Middle,	Last)				ĺ			(First, Middle				
<u>Va</u>	outd b Ment marked	2	Joseph Boyd								McCa				
Maryland 21215-0036	d 2 sh th and 7 is m traum	4 8	19a. Informant's Name/Relations Mary Tuck,		tor								own, State, Zip	CA 9344	_
<u>ရ</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28e-f show other traumatic event, the Medical Evani her must be neithed at		20a. Method of Disposition	bcep-baugii	20b. Pla	ce of Dispo	sition (Narr	e of		Da			ion - City or To		0
Ę	Pages lent of nt; tf i		1 ☐ Burial 2 🛣 Cremation  4 ☐ Donation 5 ☐ Other (S		i	metery, cren 7ans	-			1 / 1	3/09	Ī, e	ola,	РА	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Ne ODG.		21. Signature of Funeral Service	Licey ee		22	. Name and	d Addres	s of Facility	4					
-	90 = 99		John R.	dy		86	Pin	e s	tree	t, C	Fune	PA !	Home, 19363	Inc.	
			23a. Part 1. Priter the disease, or shock or heart failure. List Immediate Cause (Final	complications that caused only one cause on each lin	the death.	Do not ente	er the mode	of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	a conse vi	pe (	0	1	)					· · · · · · · · · · · · · · · · · · ·	
	Examiner		Convention list conditions	b		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							3		
40	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):									
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):									
8760	The law requires that the death certiticate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit					, .									
တ္	titicate ng phys as the	Physician/Medical	15.55	J											
Box	leath certitica attending ph I for use as ti	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal c	leath 3□	Ectopic pre	gnancy				23d.	. Date of delive	ery Day Year	
o.	at the dea by the ar	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of dea	ith 5□	Other (spe	ecify)					WOITH	Day rear	
0.	that the the the the the the the the the th		Part II. Other significant condition	ons contributing to death be	ut not result	ting in the ur	nderlying ca	use give	en in Part I.		23e. Did t	obacco use	contribute to th	ne cause of death?	
rds	w requires been signi should be	ed by					_				X	Yes 2□N	lo 3∏Prob	ably 4 DUnknow	n
eco	e law re has bei je 2 sho	Completed									24a. Was		4b. Were auto	psy findings available ripletion of cause of	е
<u>=</u>		Con										rmed? 2 No	death?	2 No	
Vita	Physician: The this certiticate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	NE:		Check onl				
of	Phys er this eral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		R/Outpatien 8b. Time of		A Bc. Injury Work	4 Nur		e 5 🗌 Resid 3d. Describe l		Other (Specify	/)	-
ion	Attending for death.	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	/ Year)	Injury	М		<br Yes 2□N	10					
Division of Vital Records,	or Attend after death Director;	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At hom c. (Specify)	ne, farm, stre	eet, factory,	office		28	3f. Location (3 City or To		umber or Rura	l Route Number,	
	Hospital or 14 hours afte Funerel Dir tely tilled in I	O	29a. Certifier 1 Certifyir	g Physician: To the best	of my knowl	ledge death	occurred a	it the tim	ne date and	d place, ar	d due to the	221150(6) 250	d mannar as at	atod	
	To the Hospital within 24 hours a To the Funerei I completely tilled	edicai	(Check only 2 Medicel one)	Exeminar: On the basis of and manner sta	examinatio	n and/or inv	estigation,	in my op	oinion, deat	h occurre	d at the time,	date and pla	ce, and due to	the cause(s)	
	To the within 2 To the complet	×	29b. Signature and title of certifie			[	29c.	License	number			29d. Date si	gned (Month,	Day, Year)	
			Who -	>		mí	7 1	0(	050	640	19	11/1	6/09	7	
	4		(1)	who completed cause of de	ath (Item 2	(Type, 1	11	<	1		103	DE F	Kton	MD 2195	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re	Tig	N	01-(	الار	100	~- U	1100	1001/0	_
	Registr		NOV 1	6 2009		4 1	Gas Hay	1							

			For State	State	of Marylar	•	artment of F		and M	_		200	0 0	. =
			Registrar  1. Decedent's Name (First, Mid	dle Last)			unicate or	Deam		2. Date of Dea	Reg. No	· 200	9 :	793
	Physici /Medi		Grace Brown	. ,						Month Nov.	13	2009	9	:30 A M
40	Examir		4a. Facility Name (If not instituti	ion, give street and n	umber)		4b. City, Town, o	r Location o	f Death		4c.	County of Dea	th	
4			2295 Biggs H	łwy.				g Sun				Cecil		
	Funeral Director		5. Social Security Number 427-58-2417	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da May 1,	th ly, Year) 193	Co	thplace (Si ountry) SISSI	ate or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. Count	ly	10c. C	ity, Town or Lo	cation						10d. Insid	de City Limits
	Mary f sh	Ö	Maryland (	Cecil		Rising	Sun						1 🗆	Yes 2 🔀 No
	the	rec	10e. Street and Number				10f. Zip Code			1	10g. Cit	izen of What Co	untry?	
	3a ol	a D	2295 Biggs Hv	<b>√∨</b> .			219	11				USA		
	deat	ner	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Orig	gin? (Spe	cify Yes or No	- T	14. Race - Ame		ın,
980	s should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes. G	2 No		il Yes, specily Cubi 1 □Yes 2 🕱 No	Specify:	, Puerto r	ricari, etc.)		Black, White Specify:	e, etc. Whit	e
2-0	72 hou natura	eted	15. Decede	ent's Education lest grade completed,		16a. Dece	dent's Usual Occup	ation	of working		16b. K	ind of Business	Industry	
Maryland 21215-0036	2 should be filed within a and Mental Hygiene. Is marked other than "" aumatic event, tre IN	omple	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done DO NOT use retire maker	d)	or working	g	Oz	wn Home		
b	il Hyg other	BeC	17. Father's Name (First, Middle	e, Last)		Tromer	iluker_	18. Mothe	r's Name	(First, Middle,				
/ar	uld be Venta rrked rric ev	To E	J.V. Bryant					Ma	rgar	ett Mal	one			
ar	2 short and I ls ma	ľ	19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	ng Address (Street	and Numbe	r or Rura	l Route Numb	er, City o	or Town, State, .	Zip Code)	
	ss 1 and 2 of Health of item 27 ls r other tra	Į.	Robert Paul H	Brown/Husb	and	2295	Biggs H	lwy.,	Risi	ng Sun,	MD	21911		
ore	ges 1 and 2 should it of Health and Mer If item 27 Is marke or other traumatic		20a. Method of Disposition 1 🕅 Burlal 2 🕅 Cremation	3 D Removed from	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce) 1	1-19	-2009	20c. Lo	ocation - City or	Town, Sta	te
Ë	. Pag tment tant: jury		4 □ Donation 5 □ Other				ingham C	emete	ry			lora, Ma	ary1a	nd
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or of		21. Signature of Funeral Service	e Licensee	o die	22	R.T. Foa 111 S. Q	ss of Facility ord Fur oueen	nera: St	l Home, Rising	P.A Sur	A. n. MD	21911	
			23a. Part1 Enter the disease, shoot, or heart failure. Li	or complications that	caused the dea	th. Do not ent							Approx	rimate I Between
	Physician		Immediate Cause (Final disease or condition	U <sub>1</sub>	-	betruch	TVC PULA	wash	dis	ease				and Death
	/Medical		resulting in death)	a.	(or as a consec		1	)	- 30		-		10 01	
	Examiner	<u>.</u>	Sequentially list conditions,	b										
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):								
<u> </u>	execunand nand	Exar	that initiated events resulting in death) Last	c Due to	(or as a consec	quence of):								
8760,	cate be executed physician and the burial-transit	dical		d										
9		ledi		1										
.O. Box	The law requires that the death certifit ate has been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	atcome of pregn birth 2☐ Feta gnant at time of nown	al death 3 [	Ectopic pregnand Other (specify) _	У				23d. Date of de Month	livery Day	Year
ď.	s that ined b		Part II. Other significant condi	_	death but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	obacco i	use contribute to	the cause	e of death?
ğ	w requires to been signer should be	ed b	Long Ma	155						1	Yes 2	□ No 3□ P	robably	4 ☐ Unknown
Division of Vital Records,	e law re has be je 2 sho	Completed by								24a. Was				ings available of cause of
e			05.116							1 □ Yes	2 No		2 □ No	·
₹		Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	TD/0.4	oth	or:		(Check only o		. Tau .:-		
of	arthis erald	Ë	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of	IL 3 LL DOA	4 L Nu		8d. Describe		6 ☐ Other (Spe	ecify)	
io	Attending r death. ector: Afte by the fune	aţio	Natural 5 ☐ Pend 2 ☐ Accident inves	ing ( <i>Moi</i> tigation	nth, Day, Year)	Injury		k?  Yes 2 □ N	No			•		
ivis	or Atte after dea Directo in by th	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined   28e. Place	e of Injury - At h ling, etc. <i>(Speci</i>	ome, farm, str	eet, factory, office		2	8f. Location (S City or Tov	Street an vn, State	nd Number or R	ural Route	Number,
_	Hospital 4 hours a Funeral tely filled	Medical Ce	29a. Certifier 1 Certify (Check only one)	ing Physician: To the	e best of my kno basis of examination	owledge, deat ation and/or in	n occurred at the ti vestigation, in my	me, date an opinion, dea	id place, a	and due to the ed at the time,	cause(s	and manner a	s stated.	use(s)
	To the within 2 To the complete	Me	29b. Signature and title of certification				29c. Licens	se number	50			te signed (Mont		ar)
	4		30. Name and address of person Pra Shant Shull 31. Date filed (Month, Day, Yea.	n who completed cau	ise of death (Ite	m 23a) (Type,	Print) #400	Abcr	dece	MO	21	00)	-	
	Sta	ite	31. Date filed (Month, Day, Yea.	r) 32. I	Registrar's Sign	ature	- 1	-						
	Registr		NOV	1 6 2009	Menera	B. 4	backer							
DHI	MH 17 Rev 1/2	001		/	O TOTAL STREET	1								

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Bertha Elizabeth Blevins November 2009 19:35 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Port Deposit Maryland 7. Age (In yrs. last birthday) 1 □ M 2 💢 F Months 215-16-9528 87 Aug. 8. 1922 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Cecil 1 ☐ Yes 2 ▼ No Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Craigtown Road 21904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2√2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Administrative Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd A. Nickle Josephine Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judson A. Blevins / Spouse 201 Craigtown Road, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State T Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 19, 2009 Port Deposit, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home ela 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Breedy couchia - 1 day Due to (or as a consequence of): LUREK Mascurca if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Week Accete renal Due to (or as a consequence of): dicistolic hecut >1 week

Physician /Medical Examiner Examiner be executed

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

Director

Funeral

Completed

Be ပ

is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-4 show other traumatic event, the Invition Exercity or intent to a withing at

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur

Baltimore, Maryland 21215-0036

68760

P.O.

Records, 7

Vital

of

Division

Hospital or Attending Physiclan:

this

within 24 hours after death. To the Funeral Director: filled in by the

completely

that the death certificate Box

attending physician and for use as the burial-trar Physician/Medical signed by the a Completed by page 2 funeral director, Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Accele colle	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
	N/PR Bladder Cancer (Resurrent) news (severe melnutrition)	24a. Was an autopsy gerformed? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No
25. Was case referred to medical examiner?	26. Place of Death (	Check only one)
1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date of Injury (Month, Day, Year) ation  28b. Time of Injury M 1 □ Yes 2 □ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ☐ Certifyin (Check only one) 2 ☐ Medical	p Physician: To the best of my knowledge, death occurred at the time, date and place, ar ixaminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bungaria

Dr. Karmal Bangaria, M.D., 501 South Union Avenue, Havre de Grace, Maryland 21078 31. Date filed (Month, Day, Year)

29c. License number

D0065641

29d. Date signed (Month, Day, Year)

15 /09

State Registrar

32. Registrar's Signature

29b. Signature and title of certifier

Hamal

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20091 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 7:03PM Barbara Brokus 11 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Manyland City Baltimore 7. Age (In yrs. last birthday) 70 Yrs. If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year 1 □ M 2 🗙 F Days Hours 219-26-8614 Director July 02,1939 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, It a Medical Examinar must be nothing a MD Anne Arundel Severna Park Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 417 Ben Oaks Drive W. 21146 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or itel Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐Yes 2 X No Specify White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred A. Jarrells Hazel D. Cooper 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Frank John Brokus / Husband 417 Ben Oaks Drive W. Severna Park, MD 21146 Baltimore, 20b. Place of Disposition (Name of Glen Haven Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 09, 1 X Burial 2 ☐ Cremation 3 Remo rom State 4 Donation 5 DOther (Specify) Glen Burnie, MD 2009 Senature of Funeral Service Licen Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muocardia Infarction days /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usasso or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. ed by the 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 👿 No 3 Probably 4 Unknown Completed cate has by page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 No of Vital Physician: : After this certification of funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural
2 Accident death. 1 ☐Yes 2 ☐ No hours after death uneral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical completely (Check only To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1043445976 11/04/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eleanor S. Greene St. Balt. more, MD 21210 22 imm 31. Date filed (Month, Day, Year) 32. Registrar's Signature park

DHMH 17 Rev 1/2001

Registrar

NOV U6

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiena 37939 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Μ. 3:37A.M. M Paula Banks 2009 11 03 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13614 United Lane Bowie Prince Georges | Brunder 1 Year | Hounder 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | November 21,1955 | Washington, 7. Age (In yrs. last birthday) 53 Yrs. 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 579-76-2877 Director Yrs. D.C. Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Exercipations be notified at Maryland | Prince George's ty⊟Yes 2 No Bowie Direct 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 13614 United Lane 20720 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: BLack þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic avent, It e M. Jit ODGS. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Consulting FIrm Administrative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Banks Sarah Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13614 United Lane Bowie, Maryland Wanda Banks (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Banks Family Cemetery 11/15/2009 Syria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee marshall 00 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician Metastatic Breast Cancer 2 vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ned by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an has ŽQXNo 1 ☐ Yes al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes ZZNo 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Matilda H. So (15 D26250 Lus November 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matilda H. So, MD 1221 Mercantile Lane Largo, Maryland 20774 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 09 2009 State neuras Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Mildred **Physician** Μ. Month Day Carey ,00 A M 05 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPICE the Lake Da bi at Wic omic If Under 1 Year 8. Date of Birth (Month, Day, Year) 02/14/1915 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 216-18-2603 Months 1 □ M 2 🔀 F 94 Days Hours Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show Maryland Director Wicomico 1XYes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave. Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Mildred Care gastinore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 Is marked other than r traumatic event, the Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Gurney W. Mezick Fannie Elizabeth Ruark ပ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16048 Emerald Rd., Stony Creek, VA 23882 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other trau once. Gregory McGrath/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 11/10/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen-Hollowayd Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day P.O. I 5 ☐ Other (specify) 1 □Yes 2 □ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy spital or Attending Physician; The hours after death.
Ineral Director: After this certificate y filled in by the funeral director, par 1 □Yes /2 □ No 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2PT186 Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) 27. Manuer of eath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hustin

31. Date filed (Month, Day, Year)

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Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

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Examin		4a. Facility Name (If not institut	-				•		cation of Death			County of		
		10225 Montgom 5. Social Security Number	6. Sex		(In ura le	ast birthday)		singto	ON. Under 24 Hrs.	8. Date of Bir		ontgo		ace (State or Fore
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aryland show	_	10a. State 10b. Coun	•			, Town or Lo							10	ld. Inside City Lim
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with the	Funeral Director	10e. Street and Number					10f. Zi					ted Sa		•
rs 23	era	10225 Montgome	_	. Was Decedent E	ver in U.S	6. 13. \	. –	0895 dent of Hispa	anic Origin? (Sp Mexican, Puerto	ecify Yes or No		14. Race -		
nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. artment of Heath and Mental Hygiene. Injury or other traumatic event, the Medical Examinar must be motified at the Medical E		1 Never Married 2 M M	arried	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			fYes, spe □Yes		Mexican, Puerto Spe <i>cify:</i>	Rican, etc.)		Black, Specify:	White, e	
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buld be f Mental I arked or atic eve	To B	Benjamin	Coher	ı					Lillian		Stras	hun		
2 should and Men is marke aumatic		19a. Informant's Name/Relatio					-		Number or Ru				_	
1 and 2 Health a tem 27 is		Wendy Lynn Mi	ller,	wife	Tool D				y Avenu	e, Kens		on, N		20895
permit. Pages 1 Department of I- Important: If ite any Injury or ot	/	20a. Method of Disposition  1		moval from State	Jud	lace of Dispo emetery, cren ean Me	mori	other place)  al Gdr	ı. 11/9/					yland
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	Licensee		709									Home, 11 g,MD 209
-		23a. Part 1. Enter the disease, shock, or heart failure. L	or complica									000		Approximate Interval Betwee
rificate be executed  Washington and as the burial-transit  Titlicate be executed as the burial-transit as the	al Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a	consequ	uence of):								
at the death certificate by the attending phys tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		c. If yes, outcome of the Live birth at Pregnant at 9 Unknown	2 ☐ Fetal time of d	death 3 E	Other (s					23d. Date Mont	h	Day Yea
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Sig d be	Completed											de	ath?	osy findings ava npletion of caus
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nysician: The law requires nis certificate has been sign director, page 2 should be	Be	25. Was case referred to medi examiner?  1 Yes 2 No		spital: 1 □ Inpatie	nt 2 🗌	ER/Outpatier	nt 3 🗆 🗆	OA	4 L Nursing H	ome 5 🔼 Res	idence	6 ☐ Other	Opecii	/)
naing Physician: The law requires ath. T. After this certificate has been sig te funeral director, page 2 should be	Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen 2 Accident	Ho ding estigation	spital: 1 ☐ Inpatie 28a. Date of Inju (Month, Day	У	ER/Outpatier 28b. Time o Injury		28c. Injury a Work?	T I Nulsing II	ome 5♠ Res 28d. Describe				/)
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e Hospital or Attending Physician: The law require: 12 Hours after death. 15 Funeral Director: After this certificate has been signetly filled in by the funeral director, page 2 should be	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pen 2 Accident inve 3 Suicide 6 Cou 4 Homicide	ding stigation and not be ermined	28a. Date of Injur (Month, Day	ry - At ho (Specify	28b. Time o Injury me, farm, str	M eet, facto	28c. Injury a Work? 1 □ Ye  ry, office  d at the time	t s 2 \( \text{No}\)	28f. Location City or To	how injur	nd Number	or Rura	I Route Number,
	Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pen 2 Accident inve 3 Suicide 6 Cou 4 Homicide  29a. Certifier 1 Certification (Check only one)  29b. Signature and title of certification (Check only one)	ding stigation lid not be ermined	28a. Date of Injunction (Month, Day) 28e. Place of Injunction building, etc. clan: To the best of err. On the basis of and manner sta	ry - At ho . (Specify of my known examina ted.	28b. Time o Injury me, farm, str	M eet, facto	28c. Injury a Work? 1 □ Ye  ry, office  d at the time	t s 2 No , date and place	28f. Location City or To	(Street arwn, State	nd Number	or Rura	I Route Number, tated. the cause(s)
ystcian: The law requi is certificate has been a director, page 2 should	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pen 2 Accident inve 3 Suicide 6 Cou 4 Homicide  29a. Certifier 1 Certification (Check only one)  29b. Signature and title of certification (Check only one)	ding stigation and not be ermined by the standard from the standar	28a. Date of Injunction 28b. Place of Injunction 28c. Place of Injuncti	y , Year) rry - At ho . (Specify of my known examina ted.	28b. Time o Injury me, farm, str /) wledge, deat tion and/or in	M eet, facto	28c. Injury a Work? 1 □ Ye  ry, office  d at the time n, in my opir	t s 2 No	28d. Describe 28f. Location City or To , and due to th rred at the time	(Street arwn, State e cause(s, date and	nd Number  a)  s) and mand place, an	or Rura ner as s d due to	I Route Number, tated. the cause(s) Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Registrar	Maryland / Dep <i>Ce</i>	artment of H rtificate of L	ealth and M Death	ental Hygier	2009	37942
	Physici	ian	1. Decedent's Name (First, Middle, Last)  Donald B. Corv				Date of Death     Month	D <i>a</i> y Year	3. Time of Death
and in	/Medio		4a. Facility Name (If not institution, give street and numb	per)	4b. City, Town, or	Location of Death	November	8, 2009 4c. County of Death	2:00 P <sup>M</sup>
mg/C			Sunrise Assisted Living			cy Village		Montgomery	-
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Social Residence of Decedent 7.	Age (In yrs. last birthday,	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea April 4,	9. Birth Cou 1926 Mont	
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	he Ma 28a-f s	Director	MD Montgomery	Montgomer					1 □Yes 2 No
	3a or	a Dir	10e. Street and Number 19310 Club House Road #31	11	10f. Zip Code 20886		USA USA	Citizen of What Coul A	atry?
က	should be filed within 72 hours after death with the Maryland nd Menfal Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Macittal Experimer usual be notified at	Funeral	11. Marital Status  12. Was Decede Armed Force 1 □ Never Married 2 □ Married 1 □ Yes 2	ZNO I	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
5-0036	ural", o	d by	3 ★Widowed 4 Divorced If Yes, Give Year or Date	es:	1 □Yes 2 🛣 No	Specify:		Specify: Whi	ıte
215-	nin 72 l e. an "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	urina most of workin	16b.	Kind of Business/In	dustry
217	led witl hygiene her tha	Com	4		uter Scier			mputer Tec	hnology
Maryland	و فر الله	To Be	17. Father's Name (First, Middle, Last)  Claude Cory			18. Mother's Name Fanny Can	(First, Middle, Maid	en Surname)	
Iary	s 1 and 2 should I f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a	nd Number or Rural	Route Number, Cit		Code)
e, ≥	1 and Health Iem 27 other tr		Carole S. Cory/daughter  20a. Method of Disposition		rest Brook			D 20874  Location - City or To	aum State
E E	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ate	osition (Name of matory or other place urney Cren			,	·
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	Z G	2. Name and Address	cremation	Service	P.O. Box	784
r			23a. Part 1. Enter the disease, or complications that cause	MO1251 Be	everly L.	Heckrotte	P.A. CI	arksville	mD 21029 Approximate
	Physician	í	shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition Pneumo						Interval Between Onset and Death
	/Medical Examiner		La de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	as a consequence of):					
L	o +	ner	Sequentially list conditions, If any, leading to immediate b. Dyscha	as a consequence of):					months
	xecuter and I-transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or Due to	as a consequence of):					years
8/00,	ficate be executed physician and s the burial-transit	dical E	d	as a consequence or).					
20 1	ertifica ling ph e as th		IF FEMALE:						
.O. Box	Prysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant   23c. If yes, outcome in the past 12 months?   1 ☐ Live birt	h 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	Ectopic pregnancy Other (specify)	-		23d. Date of delive Month	ery Day Year
'n	es that gned b	by Pt	Part II. Other significant conditions contributing to death	h but not resulting in the un	nderlying cause giver	n in Part I.	23e. Did tobacco	o use contribute to the	ne cause of death?
cords,	been s						1 Tes	2 XNo 3 Prob	oably 4 🗌 Unknown
	cate has page 2 s	Completed				,,,,,,	24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sician certificientifi	Be	25. Was case referred to medical examiner?  Hospital:		Othor	26. Place of Death	(Check only one)		aggigted.
5	ung Pnysician: The Inc. After this certificate ha funeral director, page	n: To	27. Manner of Death 28a. Date of I	atient 2 ER/Outpatier njury 28b. Time of Day, Year) Injury	i oll box	at 28	e 5 Residence  3d. Describe how inj	6 XOther (Specifiury occurred	y living
	tendir death. tor: Af the fur	catio	2 Accident investigation		M 1 □ Y	es 2□No			
	al or A s after ( I Directed in by	Certification:	determined   286, Place of	Injury - At home, farm, streetc. (Specify)	et, factory, office	28	3f. Location (Street a City or Town, Sta	and Number or Rura te)	I Route Number,
		edical C	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the besisend manner	s of examination <i>a</i> nd/or in	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as s nd place, and due to	stated. the cause(s)
1	withii To th	Me	29b. Signature and title of certifier		29c. License	number	29d. D	Date signed (Month,	Day, Year)
		-	Normand address of the second address of the		D31391		Nov	ember 10,	2009
	10		30. Name and address of person who completed cause of Suhair Abulfarag, M.D. 60	4 S. Frederi	.ck Ave. #	413 Gaith	ersbura i	MD 20877	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Begin NOV 12 2009	strar's Signature	arked			20011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per F.D. 11/17/09 Carroll County, will
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 07 2009 Joseph Nicholas Campitelli, Sr 1912 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 10 1934 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Funeral 5.220-30-6995 1 ☑ M 2 ☐ F Country) Director 216-32-6995 74 MD Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 1750 Campitelli Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Masonry Contractor Construction and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nicholas Campitelli Amelia DiPietro permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1750 Campitelli Drive Westminster, MD Rita Campitelli/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/13/2009 Lakeview Memorial Pk Sykesville, MD 21. Signature of Funeral Service Licensee 22 Prittsd Forter WI Home and Chapel, P.A. ank 412 Washington Road Westminster, MD 21157 23a. art 1 \_\_er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastah disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No ı signed by the a Id be detached f 1 Yes 2 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Physician; The this certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? æ **Division of Vital** 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier alo 4h ms 11/9/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ki AUP 5+307 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a per phys. G897 11/30/09 dk
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day AM **Physician** Audrey Pauline Calp 11 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner WICOMICO Lecional Medical Center Salisbull Peninsula 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 11, 1924 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🛛 F Maryland 217-18-8792 85 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Madical Evanture is ust be notified at 1 ☐ Yes 2X No Director Pocomoke Worchester MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21851 2023 Orchard Dr. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembler 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be file Iment of Health and Mental H Iant: If Item 27 is marked oth Ada B. Baker Sterling Lee Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6426 Canal Ave., Chincoteague, VA 23336 Deborah Rush, Daughter 20b. Place of Disposition (Name of cemetery crematory of other place)
Pine Grove United Methodist Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 18, Nov. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkton, MD 2009 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral 24 Second St., New Freedom, PA 17349 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) detached 1∐Yes 2 DNo 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 PNo filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manney Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DEDS15

Registrar DHMH 17 Rev 1/2001 5

24

State

Murla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EATERN SHINE

DE SHLISBURY MOZIROG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 7, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Helen Kathleen Duff 2009 8:16 a November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County Elkton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Maryland 66 Director 216-48-4728 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits works aţ 3a or 28a-f sh 1 X Yes 2 □ No Maryland Director Cecil Charlestown 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 201 Cecil Street, P.O. Box 399 21914 U.S.A. must Funeral items 2 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 'natural', or item dical Examiner r Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: ð White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4or 5+) the Aberdeen, Maryland Ten Years Meat Cutter of Health and Mental Hygid If Item 27 is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be John Frank McCann Helen Nickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 1635 W.Old Philadelphia Rd., North East, MD 21901 Shannon Patchell (son) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East Cemetery 11/12/09 North East, Maryland 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 Perryville, Maryland 0 1 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner be executed Due to (or as a consequence of): burialphysician a Box 68760 Physician/Medical the death certificate attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f o 9□Unknown 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate Division or Vital 1 ☐Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 일 this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) Iniury 1 ☐ Yes 2 ☐ No 2 Accident death, within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) DIMONSON OVIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1 - For State Registrar

	Dhoole		1. Decedent's Name (First, Middle, Last)					2. Date of Dear		\/ ·	3. Time of Death
	Physic /Medi		Mary Ann Dembeck					Novembe	r 07 2	2009	6:00 p <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give	street and number)			r Location of Death			y of Death	
-		7	368 Sunshine Way 5. Social Security Number 6. Sex	7. Age (In yrs.	lost hirthday	Westmi If Under 1 Year	nster  If Under 24 Hrs.	9 Date of Birth		arrol	
	Funeral Director			M 2□ME 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 17	<sup>Year)</sup> 1922	Coul	place (State or Foreign htry) MD
	yland now		10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
	e Mar ia-fsl	Director	MD Carro	11   7	Westmi	nster					1 ☐ Yes 2 ☑ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of		ntry?
	ath w	<u>a</u>	368 Sunshine Way				.157		USZ	4	
	ter de items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.8 Armed Forces? 1 ☐ Yes 2 ☐ No	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White,	
9003	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show steel Examine: must be notified at	2	3 ☐️ <b>V</b> Vidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🕵 No	Specify:		Specia	. 441	nite
5	c - S	lete	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of work	ing	16b. Kind of B	lusiness/Ind	dustry
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Maryland 21215-0036	be filec ntal Hyg id othe event,	Be	17. Father's Name (First, Middle, Last) Felix Krawczyk				18. Mother's Name	e (First, Middle, M Asia Sra		ne)	
ar y	shoul ind M i marl	ျှ	19a. Informant's Name/Relationship (Type	oe. Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number	: City or Town	State. Zic	Code)
	and 2 salth a 27 is er trai		Bonnie Cooley/Daug	ghter		Sunshine		stminste		21157	, 2000)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crer	sition (Name of natory or other place Cremation	e) ;	Date L/9/2009	20c. Location	· _	
alti	permit. Departm Importal any Inju		21. Signature of Funeral Service Lieense	-			er allivHome			1-1-	,
<u> </u>	8 g E # 9	£ 33	John K-1				gton Road		_		21157
			23a. Partit Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.							Approximate Interval Between
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	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
68760,	eath certificate be executed attending physician and for use as the burial-transit	cal Ey	d d	Due to (or as a consequ	ence of);						
<b>68</b>	ertifica ing ph e as th	cian/Medical	IF FEMALE:								
Box	eath certific attending pl for use as t	jan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3		/			ite of delive	ery Day Year
Ö	the de y the a ched t	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5□	Other (specify)				211(1)	Day real
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of Vital Records,	or Attending Physician: The law requires that the di after death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached	Completed						autops perform 1 🗆 Yes 2	ned?	prior to cor death? 1 □ Yes	mpletion of cause of 2 □ No
₹ K	siciar certif rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	ospital:	· -	Othe	26. Place of Death				110045
of	ding Phys h. After this funeral di	n:T	27. Manner of Death	1 ☐ Inpatient 2 ☐ E	28b. Time of	28c. Injury Work	4 L Nursing Ho	me 5 Reside			HOME
ion	ath. ath. ir: Aft	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		? /es 2 □ No				
Division	or Attend after death Director: /	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Numb	per or Rura	l Route Number,
Ω	pital o		29a, Certifier 1 Certifying Phys	ician: To the best of my know	uladga daath	occurred at the time	no data and alara		,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	er: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my op	oinion, death occurr	ed at the time, da	ate and place,	and due to	the cause(s)
3	To vii		29b, Signature and title of Certifier	Men	MD	29c. License	ne din	10- 1	od. Date signe	2 0	PAG
λ i	SAQ		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	malcoln	90542 n duve,	West	minite	4 M	1) 21150
	Cto	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure					1 5	5
	Sta			19 Deneur							

09-08962 Peter Demauro

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 37947

1- For State Registrar		Certificate of	Death		Reg	. No	
Physician/ 1. Decedent's Name (First,	Middle,Last) Peter Dav				Date of Death     Month     I	Day Year	3. Time of Death 1620 hrs
edical Examiner		eMAURO	0'1		November	8, 2009 4c. County of Death	
4a. Facility Name (if not ins 27035 Gillette Dri	titution, give street and number) Ve	41	o. City, Town, or Li Crisfield	ocation of Death		Somerset	'
Funeral 5. Social Security Number	6. Sex 7. Age (Ir	n yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or Foreign
Director 150-40-9628	1XM 2F	61 Yrs.	Months Days	Hours Min.	09/27/		w Jerse <u>v</u>
Usual Residence of Deced		c. City, Town or Location	n				10d. Inside City Limits
7 00 41		,		c: .1.2			1 Yes 2 X No
pure Notes   10a. State   10b. Co	omerset	-	10f. Zip Code	field	10g	. Citizen of What Cou	ntry?
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t in the part of t	Armed Forces		Decedent of Hisp s, specify Cuban,	anic Origin? ( Sp			ican Indian, Black,
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15. Decedents Education  16. Decedents Education  17. Feather's Name (First, Market (First, Market))  18. Decedents Education  19. Decedents Education  19. Decedents Education  19. Decedents Education  19. Decedents Education  19. Decedents Education		during mo	st of working life. I				ŕ
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Peter A. Del	fauro	19b Mailing		Edith G		er, City or Town, State	e Zin Code)
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20a. Method of Disposition		20b. Place of Disposi	tion (Name of cem			20c. Location - City of	
Baltimore, MD 21215-00036  Beautiffmore, MD 21215-00036  Beautiffmore, MD 21215-00036  Beautiff and bearing with the Maryland Department of Health and Mental Hygiene  The Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner must be notified at once injury or other transmitic event, the Medical Examiner and the Medical Examine	mation 3 Removal from State	Crematory of	, ,	11/2	0/2009	Delmar, De	laware
21 Signature of Funera S	ervice Licensee			of Facility BR	ADSHAW &	SONS FUNE	RAL HOME
MAY'T ROPYNOR	radshaw Pruitt	30	6 W. Mai	n Stree	t - Cris	field, Mar	yland 21817 Approximate Interval
Physician /Medical  23a. Part I. Enter the disea			e mode of dying, s	such as cardiac o	r respiratory arres	st, snock, or neart	Between Onset and Death
xaminer Immediate Cause (Final di or condition resulting in de							Douti
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	e Due to (or as a consequ Cause	ence of):					
E (Disease or injury that initi	ated C	ence of):					
icate be executed the burial - transit the burial -	d. AMENDED # -						
Medi	23c. If yes, outcome	er ME g898	12/17/09	9 TT		23d. Date of delive	ry
23b. Was decedent pregna past 12 months?	nt in the 1 Live birth	<sub>2</sub> Fet	al death 3	Ectopic pregna	ancy	Month	Day Year
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		ut not resulting in the u	nderlying cause gi	iven in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
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eco he law age 2 a					perform 1 <b>✓</b> Yes 2		
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A comment of the comm			3 DOA	learner!		Residence 6 🗸 Oth	er: Scene
	28a. Date of Injury (Month, Day, Year	28b. Time of Ir		y at Work? es 2 No	28d. Describe h	ow injury occurred	
Division  In or Attraction  In	Investigation 28e Place of Injur	y - At home, farm, stree			28f. Location (S	treet and Number or F	Rural Route Number, City
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	ring Physician: To the best of my k	nowledge, death occur	red at the time, da	te and place, and	due to the cause	e(s) and manner as sta	ated.
욕 등 등 급 으 one) 2 🗸 Medic	al Examiner: On the basis of examin	nation and/or investigat			at the time, date a		
Some To To To To To To To To To To To To To	and manner stated.		00-11				
He did not be the first of the	and manner stated.		29c. License			29d. Date signed (M November 19, 2	
29b. Signature and title of	and manner stated.	th /Itom 22a\	0.C.M			November 19, 2	
29b. Signature and title of	and manner stated.			И.Е. 	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2009 11:40A M Nov. Betty G. Egan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1210 Oak Harbor Court Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 27, Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1941 **Funeral** Days Hours 1 □ M 2 🕅 F 68 Virginia 220-38-6418 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and; injury or other traumatic event, the Medical Experiments 200 or 200ce. 21122 USA 1210 Oak Harbor Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No 11. Marital Status 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker/Real Estate Agent Home/Realty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfred Lyle Farrar Katherine H. Hackett ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurie Freitag/Daughter 442 Riverside Drive Pasadena, MD 21122 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 2009 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funderal Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 Approximate Interval Between Onset and Death 23. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** mO disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year signed by the a d be detached for 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 XYes After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 Z N 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 2 | N Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide e Funeral 29a. Certifier Dectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 26 Name and address of person who completed course of death (frem 23a) (Type, Print) 30 10 Lucy 31. Date filed (Month gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Elizabeth M. Feldmeyer 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salis Wicomic oasta at the HOSDICO Lake 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛛 F Months Days Hours Director Oct. 24, 1912 Washington D.C. 213-18-0204 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be nother traumatic and in the Madical Examinat must be nother than any Injury or other traumatic event, the Madical Examinat must be nother. Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 1109 S. Schumaker Drive 21804 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Elizabeth Feldmeyer Baltimore, Maryland 21215-9036 1 □Yes 2X No Specify ģ Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 10 Income Tax Division 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mamie Cromwell Jim Parks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 927 W. Schumaker Manor Drive Salisbury, MD 21804 Allen Stallings (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11-06-2009 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service License aval Delmar, DE 13 East Grove Street 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAMRN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/51No 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 1No 6 Other (Specify) HOSPICA Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury Natural 5 ☐ Pending investigation 124 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Division of Vital Records,

To the Hospital o completely

State

6 Hurson

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box

32. Registrar's Signature

WANY

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 28b,d,f per me,g898,12/18/09dhb

Reg. No. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 TERALD LEWIS GRIFFIN /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 616 W Wicomico MAIN ST RUTLAND 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Sex 12 M 2 ☐ F Months Days Hours 219-36-5614 Usual Residence of Decedent Min. Director the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Prodict Examinat must be notified at Director 1 Kyes 2 ☐ No FRUITHAND MD WICOMICO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, II: Medical Experimentials bearing that in the fired that the fired th 616 W MAIN ST 21826 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Facil, Lies management THOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ROLAND GRIFFIN SR BAKER DOTAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Rout! Number, City or Town, State, Zip Code) WANDA GAIFFIN ( WIFE) 616W MAINST, FRUITLAND, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State TVASKIN (lemetery 11)
22. Name and Address of Facility 11-4-2009 TURSKIN, MD 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICKFUNETAL HOME POBOXEI BIVALUE, MDG/814 Approxi ate Interval Between Onset and Death Immediate Cause (Final **Physician** Junshot would disease or condition resulting in death) to read Self intlicted 1 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off as the burial-transi and Due to (or as a consequence of) 68760. physician Physician/Medical attending Box IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Pregnant at time of death P.O. I ed by the a detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown certificate has been signed l irector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Hospital: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directorials. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Medical Certification: To 28d. Describe how injury occurred Subject shot self. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? FOUND of 1 Natural 5 ☐ Pending investigation 1500 1 ☐ Yes 2 No 2 Accident 10130109 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 616 W. Main Street determined 4 Homicide Residence Fruitland, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1450497 11/3/04 51 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 21842 0.0 Ocean Cit 100 Ecarroll. St. Thris Suyour 31. Date filed (Month. NOV ()

Registrar DHMH 17 Rev 1/2001

State

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32. Registrar's Signature

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2009

		1	for State Registrar	State of M	aryland / De	epartment of I Dertificate of	Health and Death	Mental Hy	giene 200	9 3795
	Physici /Medio Examir	cal	Decedent's Name (First, Middle,     Thomas J. Gate     4a. Facility Name (If not institution,	Ly		4b. City, Town, (	or Location of De	2. Date of Dec Month November ath	ath Day Year 12, 2009 4c. County of Deat	3. Time of Death
	Funeral Director		218-07-8588		ge (In yrs. last birth 88 Yr	day) If Under 1 Year		rs. 8. Date of Birt		hplace (State or Foreign untry)  MD
	the Maryland r 28a-f show notified at	irector	Usual Residence of Decedent  10a, State 10b. County  MD Howal  10e. Street and Number	rd	10c. City, Town of	or Location  Ott City  10f. Zip Code			10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No untry?
5-003b	n 72 hours after death with the Maryland "natural" or items 23a or 28a-f show edical Examiner must be notified at	d by Funeral Director	4740 Gawain Driv  11. Marital Status  1 Never Married  Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2☑ No		(Specify Yes or No- erto Rican, etc.)		rican Indian,
Ċ	within 72 jiene. r than "na the Medic	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 8		ecedent's Usual Occul Give kind of work done fe. DO NOT use retire Enginee	during most of w	vorking	16b. Kind of Business/ Industrial	Engineering
aryian	should be ind Mental marked o	To Be	17. Father's Name (First, Middle, La James Thomas Gat 19a. Informant's Name/Relationship	ely	19b. A	failing Address (Street	Adelai	ame (First, Middle,  de Franz  Rural Route Numbe	Maiden Surname) er, City or Town, State, 2	?ip Code)
າ ຂໍ້ເຄ	rages 1 and 2 nent of Health s ant: If Item 27 is ary or other tra		Doris E. Gately  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	Removal from State	20b. Place of D	40 Gawain lisposition (Name of crematory or other pla	Drive El	licott C		043 Town, State
Dall	permit. Pages Department of Important: If is any injury or of		21. Signature of Funeral Service Li  23a. Part1. Enter the disease, or co	malo	0845	22. Name and Address 4112 Old (	ess of FacilityHa Columbia	rry H. Wi Pike Ell	itzke's Fam Licott City	ily F.H.Inc. , MD 21043
7	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	_a	is ho a consequence of)	sis				Interval Between Onset and Death MONTHS
00/00,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last	с	a consequence of)					
.O. DOX O	y the attending I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	very Day Year
r (epio	equires triat	þ	Part II. Other significant condition	s contributing to death b	ut not resulting in th	e underlying cause giv	en in Part I.		obacco use contribute to	the cause of death?
ion The law	his certificate has b	Be Completed	25. Was case referred to medical examiner?				26. Place of D	24a. Was a autop perfor 1 Yes	sy prior to o med? death? 2 No 1 □ Yes	topsy findings available ompletion of cause of 2 No
or Affording Bhari	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To E	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of init	ry 28b. Tim y Year) 28b. Tim Inju	ry Wor	4 ⊔ Nursing ry at	28d. Describe h	ence 6 Other (Specow injury occurred  itreet and Number or Runn, State)	
the Hospit	thin 24 hours the Funera	Medical C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	t examination and/o	eath occurred at the til or investigation, in my o	opinion, death oc	curred at the time, o	cause(s) and manner as date and place, and due	to the cause(s)
51		_	30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Ty	D	51018		29d. Date signed (Month)	
	Sta Registra		Douglas Pinto, 31. Date filed (Month, Day, Year) NOV 12	MD 3421 Ben 2009 32. Registra	ar's Signature.	e Suite 23	30 Balt	imore, MI	21227	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 20 AM MAG EVA GENTRY NOV 2000 /Medical lo 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year 5/24/1924 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 XF Min Director 295–22–9836 85 OH Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examination in 181 by notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner mest be notified at Director 1 ☐ Yes 2 XNo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Pt. Rd. #114 21044 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerical Work US Capitol 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moses Martin Minnie Courtright ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Virgil Gentry / Husband</u> 5400 Vantage Pt. Rd. #114, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or ott Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 11/12/2009 | Crownsville, MD 21. Signal re of Femeral Service L M01411 22. Name and Address of Facility Harry II. Witzke's Family FII, Inc. 4112 Old Columbia Pike, Ellicott City, MD 21043 01-1 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** interction Myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cardiovayopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit Afheroschrotic Card 10 Kascular Disruse Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery In the past 12 months?
1 ☐ Yes 2 ☑ No 3 - Ectopic pregnancy Month 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hypothy nordram 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Ves 2 No certificate Valvalar heart disease 1 ☐ Yes 1 ☐ Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 2 ER/Outpatient 3 DOA funerai 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation spital or Attendi lours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WM DO043662 NOV 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Buyce

31. Date filed (Mo

Howard

Registrar's Signatu

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Columbia MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ となる。 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington n 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Min. Director Yrs. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA SSI na 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: 3 X Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done ( life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, aven Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of F P.O. Bx 2593 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physicians disease or condition Medical resulting in death) Due to (or as // c nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause E to Undrying Cause (Disease or iinjury that initiated events Examiner Due to (or as a conse wence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 21 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Tyes Yes 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita ည 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical within 24 hor To the Funel 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge death or and still time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge death or and still time, date and place, and due to the cause(s) and manner stated. (Check Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar Signature

Kenneth L. Howell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 T = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Kenneth Lee Howell 9 2009 2115 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Care Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☑ M 2 □ F 45 21, 213-70-2599 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f shov event, the Medical Examiner must be notified at XXYes 2 □ No Director Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21222 U.S.A. 3706 North Point Road 23a Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 2 💟 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2√□No Specify Specify: White \$ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MARCOR marked other than Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland Eleven Years Laborer 18. Mother's Name (First, Middle, Maiden Surname) Alth and Mental H 17. Father's Name (First, Middle, Last) Be Lowell D. Howell Diane Warlick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5288 Pulaski Hwy., P.O.Box 153, Perryville, MD 21903 Health em 27 i Lowell D. Howell (father) other t If item 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Injury or 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Important: It any Injury or R.A.Ferris & Co., Inc. 11/12/09 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Lee A. Patterson & Son Funeral Home, 21. Signature of Funeral Service Licensee 21903-0766 Perryville, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Cancer with metastage **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of): physician requires that the death certificate be Physician/Medical use as the attending REFEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 Tyes 2 No. the g | Unknown þ signed by I pe deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 🗌 No 3 Probably 4 X Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an page 2 certificate has autopsy performed? 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 F 1 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician:

hours after death.

uneral Director: A

ely filled in by the fu within 24 hours a

To the Funeral C

completely filled Hospital Medical

29a. Certifier

(Check only one)

29b. Signati

🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year,

Battimore,

Johns Hopkins Burton pavillion

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) \_14<sup>Day</sup> Month Nov. 2009 12:17 p M Robert Lee Hogue Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Cecil E1kton Union Hospital 9. Birthplace (State or Foreign Country) Texas If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) May 14, 1930 7. Age (In yrs. last birthday) 5. Social Security Number 1 XM 2 □ F Months Days Hours Min 467-42-5580 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Rising Sun Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21911 USA 341 Red Pump Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Navy/ Military Seabee Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie Marie Nivens Robert Cecil Hogue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 341 Red Pump Road Rising Sun, Maryland 21911 AnnieMarie Hogue/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/19/2009 Rosebank Cemetery Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licenses 111 S. Queen Street, Rising Sun, Maryland 21911 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final pocardial noborchion disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Ye ar Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an TPER TENSION autopsy performed? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

P.O. Box 68760, Division of Vital Records,

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit cate has been signed by the a page 2 should be detached to certificate director, After this funeral after death. filled in by the within 24 hours a

To the Funeral I

completely filled

**Physician** 

**Examiner** 

**Funeral** 

**Director** 

th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Medical Experiment mast be notified at

Health tem 27 i or other

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

**Physician** 

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Director

Completed by Funeral

Be

/Medical Sequentially list conditions, if any, leading to immediate cause. Enter the continuous (Disease or injury Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 HUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Chronic obstructive polmonary 25. Was case referred to medical examiner? Be 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 14,2009 069204

DHMH 17 Rev 1/2001

State Registrar

4+1VA

Hospiral

32. Registrar's Signature

106 BOW ST, Elkron, MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savio

Union

Peter

31. Date filed (Month, Day, Year)

09-08563		Please Type or Print in Black In				egible.	
Christopher Devo					lygiene	200	9 37956
		Registrar  1. Decedent's Name (First, Middle,Last)	rtificate o	T Death	2. Date of De	Reg. No. 200	3. Time of Death
Physicia Medical Examir		Christopher DEVON HE	al E		Month Novembe	Day Year er 4, 2009	0610 hrs
		4a. Facility Name (if not institution, give street and number)  John Powell Rd. / Rt. 300		4b. City, Town, or Location of Deat Sudlersville	h 	4c. County of Death Queen Anne's	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mil		irth(MM/DD/YYYY) 9. Bir Foreig	
Director	-	2)8 - 84 - 53 7 4   1 M 2 F   37	Yrs	S	6-2	8-1972 Co	untry) MARY JAND
w any		100,0000	, Town or Loca				10d. Inside City Limits  1 Yes 2 No
ryland a-f sho	횽	DEAWARE SUBSEX 1	)Elmar	10f. Zip Code		10g. Citizen of What Cou	
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	12049 LINE ROAd		19940		U.SA	
th with	era	11. Marital Status  1 Never Married 2 Married 2 Married Armed Forces?		as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puert		o- 14. Race - Amer White, etc.	ican Indian, Black,
ter dea	Fun	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 No specify:		Specify: Bla	ack
ours af	d be	15. Decedent's Education (Specify only highest grade completed)		nt's Usual Occupation (Give kind of nost of working life. DO NOT use re		16b. Kind of Business/	ndustry
5-0036 led within 72 hours after de Hygiene. other than "natural", or the Medical Examiner mu	pleted	Elementary/Secondary (0-12) College (1-4 or 5+)		borer		None	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Comple	17. Father's Name (First, Middle, Last)		18.Mother's Nam	( )	Maiden Surname)	
21215-(	Be	DENNÍS DEVON HALE  19a. Informant's Name/Relationship (Type, Print)	10h Mailin	REGINA g Address (Street and Number or			Zin Code)
MD 2 ad 2 shoul ulth and IA n 27 is m aumatic	ř	TERRI L. HALE - WITE	12.04		Delmar		
re, had I and CHealth	-	20a. Method of Disposition 20b.	Place of Dispo crematory or o	sition (Name of cemetery, ther place)	Date	20c. Location - City or	/ ,
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		4 Donation 5 Other Specify:	alisbur	7	9-09	SAKSbur	y, Maey)and
Balti permit. Departm Importa		21. Signature of Funeral Servic Litensee	100	Name and Address of Fallity  EWOR FullERAL	ent 82	1 West Rd C	salia and
Physician	1	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each lipe.			or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
// Medical kaminer		Immediate Cause (Final disease a. Multiple Gunshot Wour					Death
		or condition resulting in death)  Due to (or as a consequence of Sequentially list conditions,	of):				
	iner	frany, leading to immediate cause. Enter Underlying Cause	of):				
ecuted and transit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseq	of):			-	
	lical	UNPENDED X AMENDED 28d, per 1	WE C899	1/28/10 TT	-		
68760, certificate be nding physici	Me	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	inancy	etal death 3 Ectopic pregr	ancy	23d. Date of deliver Month	y Day <b>Y</b> ear
Ox 68760, eath certificate be ex attending physician for use as the burial	Physician/Medic	past 12 months?  4 Pregnant at time of de	noth -	ther (Specify)		Monar	101
b. Box the death c	Phys	Part II. Other significant conditions contributing to death but not r	esulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?
P.C es that igned	<u>اھ</u>				1Y	es 2 No 3 Pro	bably 4 Unknown
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tal Reco cian: The law certificate has					1 ✓ Yes	formed? death? 2 No 1 Y	es 2 No
Vital Rec ysician: The I his certificate the director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatier	26.Place of Death (Check at 3 DOA Other Nurs	k only one) sing Home 5	Residence 6 🗸 Othe	r: Scene
of Vital Records, ing Physician: The law requir After this certificate has been stumeral director, page 2 should	<u>ان</u>	27. Manner of Death  28a. Date of Injury  No. (Mgntby Deat Year)	28b. Time of 0600 hrs	Injury 28c. Injury at Work?	28d. Describe	e how injury occurred ot by law	
Division ratending or Attending and or Attending and Director:	catic	2 Accident Investigation 28e Place of Injury - At h		1 Yes 2 ✔ No eet, factory, office building, etc.	enforce	•	ural Route Number, City
Division of Ppital or Attending Phours after death.	Certification:	3 Suicide 6 Could not be determined (Specify) Local Stre		,	or Town,		
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.					
7.37.8	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
. ~ 1		30 Name and address of person who completed cause of death (Iten	n 23a\	O.C.M.E.		November 5, 20	
legu		Russell Alexander MD Assistant Medical Exar		1 Penn Street, Baltimore, N	MD 21201		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 2009 32. Registrar's Signat	D. Asi	uke		•	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lee Francisca Но 2009 3:50 a November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Heartland Health Care Center Adelphi 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 屎 F Months Days Hours Min. April Day O ear) 1942 220-58-5643 67 Yrs Philippines Director Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🌁 No Maryland Prince George's New Carrollton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 20784 USA 5708 83rd Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 K Married 1 ☐ Yes If Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 🛣 No Specify: "natural" 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 27 is marked or traumatic even ဂ္ Unknown Lee Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5708 83rd Place, New Carrollton, MD 20784 je 1 and 2 s t of Health a If item 27 i Andres Siy Ho/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1x Burial 2 ☐ Cremation 3 ☐ Removal from State ō 2009 injury 6 George Washington Cemetery Adelphi, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. any 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause /Final Physician Acute Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Cardiac Arrhythmia Sequentially list conditions, it any cause. Enter Underlying Examiner Due to or as a construence of and -transit Stroke executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Anemia or Attending Physician; The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the detached Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by the þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 2 😾 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes XX No 1 Inpatient 2 ER/Outpatient 3 DOA ြို 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this nours after death.

neral Director: After this filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined hours after building, etc. (Specify) Hospital within 24 hours a To the Funeral I completed filled

State Registrar

Medical

29a. Certifier

31. Date filed (Mont

29b. Signature and title of certifie

Chandeseller

Chandra Korapati,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signatur

To the

1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7207 Hanover Parkway, #B, Greenbelt, MD 20784

MD52855

29d. Date signed (Month, Day, Year, November 6, 2009

		•	State Registrar		Cei	rtificate	of Deati	h		Reg. No. 2	009	37958
		П	Decedent's Name (First, Middle, Last)					2.	Date of De	ath Day	Year	3. Time of Death
6	Physicia /Medic		Charles E. Hopk	ins Sr					Month NOVE	MBER 1	2009	12-40 AM
1	Examin	_	4a. Facility Name (If not institution, give s	street and number)		4b. City, Tov	vn, or Location	n of Death			nty of Death	
		п	Lorien Medical	Center			umbia				ward	
ha.	Funeral Director		5. Social Security Number 6. Sex 213-34-9595	7. Age (In)	vrs. last birthday) 72 Yrs.	If Under 1 Y Months D	ear If Unders	er 24 Hrs. 8. Min. J	Date of Bir (Month, Pa a.n.	th Year) 37	9. Birthpl Coun. Mary	lace (State or Foreign try) 'Iand
	pu ,		Usual Residence of Decedent	100	City, Town or Lo	eation					1	0d. Inside City Limits
	arylar show d at		10a. State 10b. County			CallOII					1.	1 □ Yes 2 No
	Ba-f :	Directo	Maryland Anne Ar	undel S	Severn					40 - 011	- 6 18/1 1 00	
	or 2		10e. Street and Number			10f. Zip Co					of What Coun	uye
	ath w	<u>a</u>	7603 Northwood			_	1144	0-1-1-2 (015			SA Race - America	an Indian
	er de	Funeral	11. Wantai Status	12. Was Decedent Ever i Armed Forces?	n U.S.   13.	was Deceden If Yes, specify	Cuban, Mexic	Origin? (Specif can, Puerto Ric	an, etc.)	)- 14. I	Black, White,	
Baltimore, Maryland 21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	۾	1 ☐ Never Married	1  Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2火		fy:			ecify: Bla	
5-		Completed	15. Decedent's Educ (Specify only highest grade	cation co <i>mpleted)</i>	16a. Dece	dent's Usual C kind of work of DO NOT use r	occupation done during m	ost of working		16b. Kind o	f Business/Inc	dustry
7	should be filed within and Mental Hygiene. s marked other than " umatic event, the Mer	핕	Elementary/Secondary (0-12)	College (1-4or 5+)		:lift (				Gome	oljak	
2	filed w Hygie other t		17. Father's Name (First, Middle, Last)	0	LOLIN	.1110		ther's Name (F	irst Middle			
ī	be fi	Be									iamo)	
yla	should and Men s marke umatic	2	James Hopkins		401 44:33			rgaret nberor Rural F			un Ctato Zin	Codol
Jar	2 sho		19a. Informant's Name/Relationship (Type									
4	1 and 2 Health tem 27 i		Frances Hopkins					Estat			vern, on - City or To	Md. 21144
9	Pages 1		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R		b Phice of Diso cemetery, cre			1				_
Ë	ттел tant: jury		4 ☐ Donation 5 ☐ Other (Specify)		Memoria			11-6-		- /	polis,	, Ma.
Ball	permit. Page Department Important: If any Injury or		21. Signature of Funeral Service License	o MOOK83				Sons Anna		-		01
3-			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the c	leath. Do not en	ter the mode o	f dying, such	as cardiac or r	espiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Cause (Final		EPTICE	EMIA					1	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con								
	Examiner											
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a con	sequence of):							-
	uted d ansit	Examiner	that initiated events									
oʻ	exection and and rial-th		resulting in death) Last	Due to (or as a con	sequence of):							
68760,	rificate be executed ng physician and s as the burial-transit	Medical		1								
	ng ph	edi			<u> </u>							
Вох	attendin for use		23b. was decedent pregnant	3c. If yes, outcome pf pro		⊒Ectopic preg	nancv			23d.	Date of delive	
	deat e atte	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown		Other (speci					Month	Day Year
P.0	t the by th tache	hys	9 ☐ Unknown	9LI OII KIIOWII								
	The law requires that the death ce are has been signed by the attendi bage 2 should be detached for use	by P	Part II. Other significant conditions con		_				23e. Did	,		ne cause of death?
ğ	w require been sig should b	De la	CHRUNIC KII			FUN / IN	UTON L	MUKBA	1 🗆	Yes 2. N	o 3 Prob	oably 4 □Unknown
ပ္ပ	aw re	et	FAILURE	TO THRIVE					24a. Was	an 24	4b. Were auto	ppsy findings available mpletion of cause of
Re	The lav te has age 2	Completed							auto perf	ormed?	death?	2 □ No
ta	ician: Th certificate rector, pag		25. Was case referred to medical				26. Pla	ace of Death (				20.10
>	ysician: The is certificate hadirector, page	To Be	eyaminer?	lospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA	0	Nursing Home			Other (Specil	(v)
Division or Vital Records,	a Physer this eral of		27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c	Injury at Work?			how injury oc	_	
on	nding th. :: Afte	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	(r) Injury	M	1 Yes 2	□No				
/isi	Atter dea sctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury -	At home, farm, st	reet, factory, o	ffice	28		(Street and No	umber or Rura	al Route Number,
Ö	afte Din din l	Certification:	4 ☐ Homicide determined	building, etc. (Sp	reony)				Oily or ro	wii, Olale)		
	spita neurs nera y fille		29a. Certifier 12 Certifying Phys	sician: To the best of my	knowledge, dea	th occurred at	the time, date	and place, an	d due to the	e cause(s) and	manner as s	tated.
	e Ho	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examend manner stated.	mination and/or ii	ivestigation, ir	і ту оріпіоп,	death occurred	at the time	, date and pia	.ce, and due t	o the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; p.	Me	29b. Signature and title of certifier			29c. L	icense numbe	er 2/ 214			gned (Month,	
	1)11		Alling	MD			D006	66 34		MoA	. 2,	5001
	KH		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	Print)	0	. 0. 4		en a (	0 0 04	A 2
	3		30. Name and address of person who co	v AWAN	10862	14 1CK	· My R	DUE.	20	CLUM	14 M	0 2/0 44
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 3, 2009 Physician 2507 Kukic Anka /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 11506 Bucknell Drive, Apt 102 Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □XF October 10, 1930 Europe 79 Director 579-31-4972 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exp. instrumatic event, the Modical Exp. instrumatic event, the Modical Exp. instrumatic event, the Modical Exp. instrumatics. 1 ☐ Yes 2 ☐ No Silver Spring Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Europe 20902 11506 Bucknell Drive, Apt 102 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) " Health and Mental H. " m 27 is mark." Be Ljuba Diklic Budimir Milevsnic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11506 Bucknell Drive, Apt 102, Silver Spring, MD 20902 Zeljko Kukic-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery November 7, 2009 Burtonsville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Fleck Funeral Home, INC. M01234 7601 Sandy Spring Rd., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NS **Physician** WAYXIQ disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 I Unknown 9 Unknown à signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performe certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After 1 Natural 5 Pending 930 M 1 ☐ Yes 2 No hanging investigation 5614 NOV 3 2009 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Numb City or Town, State) / 1506 | State State 4 ☐ Homicide Moone Silver Spr1 " mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and may ner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the within 7 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier D 20428 2 DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

NOV U 6

09-08298 Benjamin Jame	s Ke	Please Type or Print in Black Indelible In				
Donjamin came	• • • • • • • • • • • • • • • • • • • •	1- For State Certificate of			2009	3796
Physici	an/	1. Decedent's Name (First, Middle,Last)		Reg 2. Date of Death	No.	3. Time of Death
Medical Exami		Benjamin James Kelly III			2009 Year	0122 hrs
*			c. City, Town, or Location of Dea		4c. County of Death	
		Prince Georges Hospital	Cheverly		Prince George	e's
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. Biri	thplace (State or
Director		577-98-3436 1XM 2 F 32 Yrs.	Months Days Hours Mi	n. 08/20	)/1977 Foreig	in untry) DC
2		Usual Residence of Decedent		00720	7/ + 7//	" DC
		10a. State 10b. County 10c. City, Town or Location	n -			10d. Inside City Limits
P P B	_	MD Prince George	Largo			1 X Yes 2 No
aryla	5	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a injury or other traumatic event, the Medical Examiner must be notified at once.	Director	914 Delran Place	20774	11	nited Stat	A C
with <b>with</b>	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? ( §		14. Race - Ameri	
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6 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use re	tired)		
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215-0036 be filed within 7 ntal Hygiene. "ked other than ent, the Medica		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
2121 Vuld be i Mental marke	Be	Benjamin James Kelly, Jr.		oinette J		
D 2 shoul rind M	2		Address (Street and Number or			
MD and 2 sho salth and 2 sho		Keisha Hogan 40 Che 20a. Method of Disposition 20b. Place of Dispositi	esapeake Street			-
of He If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other		Date 2	20c. Location - City or	I own, State
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation 5 Other Specify: Resurrecti	on Cemeterv 11	/07/09	Clinton, M	larvland
Salt ermit eparti oport		21. Signature of Funeral Service Licensee 22. Na	me and Address of Facility St	ewart Fun	eral Home.	Inc.
		Sohn J. Stewart 400	Di Benning Rd.	NE Washi	ngton, DC	20019
Physician /Medical		234 Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Examiner,	8 8	Immediate Cause (Final disease a <u>Multiple stab wounds</u>				Death
		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of);				<del> </del>
108 a E	Examine	events resulting in death) Last Due to (or as a consequence of):				_
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Box 68760 e death certificate b the attending physi ed for use as the bu	Ě	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	Literation 2 Establishmen		23d. Date of delivery	
C 68	흥	past 12 months?	death 3 Ectopic pregn r (Specify)	ancy	Month D	ay Year
BO)	ysi	1 Yes 2 No 9 Unknown g Unknown	( Opecany)			
P.O.		Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ries th	d by			1 Yes	2 ✔ No 3 Prob	ably 4 Unknown
requestion peen	Completed			24a. Was an		opsy findings available
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	o Be	examiner? Hospital:		ng Home 5 Re	sidence 6 Other	
n of Viling Physical differenti		27. Manner of Death 28a. Date of Injury 28b. Time of Injury		28d. Describe how		
adin rth.	틸	1 Natural 5 Pending 10 / 36 / 00	1 Yes 2 X No		stabbed se	1f
isic recto	<u> </u>	2 Accident Investigation 13 X suicide 6 Could not be 28e. Place of Injury - At home, farm, street,		28f Location (Stre	et and Number or Rur	al Route Number, City
Est on Transport	ertification:	3 X Suicide 6 Could not be determined Specify house	Terrory, emer Parising, etc.	or Town, Stat	e)	-
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	ပ	29a. Certifier	d at the time, date and place, and		St Lothian	
To the I within 2 To the I complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation	n, in my opinion, death occurred	at the time, date an	s) and manner as state d place, and due to the	cause(s)
To COT	Me	and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
		2-1	O.C.M.E.		October 26, 2009	
	-	30. Name and address of person who completed cause of death (Item 23a)	1			
,		_	Penn Street, Baltimore, M	ID 21201		
Sta	ate	31. Date filed (Month Day Kear) 32. Registrar's Signature		_	<del></del>	
Poglet		MILLY A D CLAUS / Machine M ARCHITECT				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Helen M. Lacey November 5, 2009 6:00 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis Health Care Severna Park Anne Arundel Severna Park 5. Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours 93 212-16-5390 Aug. 8, 1916 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1751 Broadlee Trail 21401 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □Never Married 2 □ Married 1 ☐ Yes 2000 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Nursina 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roland Meade Anna Norfolk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharie L. Valerio/daughter 1751 Broadlee Trail Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State Baltimore Crematory 11/6/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Servige Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 0% 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCIEROTIC CARDIOVASCULAR DISCASC YEARLS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autoosy 20 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

t be notified at

ms 23a

"natural", or iten dical Examiner

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Department of Important: If it any injury or o

al Hygiene.

2 should be fill and Mental H

Pages 1 and 2 should nent of Health and Mer

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Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed burial-tran attending physician the as nse for signed by the a d be detached for certificate Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

To the I within 2.

in the past 12 months? Yes 2 No 9 T Unknown

1 Yes 2 46 27. Manner of Death

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28c. Injury at Work? 28b. Time of 1 🗌 Yes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a, Certifier

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and

6 ☐ Could not be

determined

D31136

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE AU, BALTIMONS, MED 21236

C. WALLACE, MI) 9005 31. Date filed (Month

Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylar		artment of H rtificate of			giene Reg. No. 200	9 37962		
ľ	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Dorothy M. Lewis						2. Date of De Month Novembe		3. Time of Death 009 3:07 p M		
d d	Examin		Anne Arundel Medical Center Annapolis							4c. County of Death Anne Arundel			
	Funeral Director		5. Social Security Number 435–28–2960	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year) 9, 1920	Birthplace (State or Foreign Country) Louisiana		
	Maryland f show	ror	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel	10c. Ci	ty, Town or Lo					10d. Inside City Limits 1 ∐Yes 2 [X]No		
	with the I 3a or 28a	Funeral Director	10e. Street and Number 318 Rosslare	Drive	ļ		10f. Zip Code	21012		10g. Citizen of What	at Country? USA		
336	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Medical Evaning or must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	rried Armed Fo	2 XNo ve		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🏿 No	lispanic Origin? (§ an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White		
21215-0036	within 72 hou ene. than "natura	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker						rking	16b. Kind of Business/Industry  Home			
Maryland 2	e d ta	To Be Co	17. Father's Name (First, Middle Eugene McGuir	. ,		1	Totalate	18. Mother's Nar	me (First, Middle, ma Flynn	Maiden Surname)	AIIC .		
	2 s nar is		19a. Informant's Name/Relation Stewart E. Le							er, City or Town, St MD 21012			
Baltimore,	Pages 1 and ment of Healtl ant: If Item 27 ury or other t		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 4 ☐ Donation 5 ☐ Other (3		State I		sition (Name of natory or other place Cremator		09 <sup>Date</sup>	20c. Location - Ci	ty or Town, State Burnie, MD		
Rail	permit. Page Department or Important: If any injury or once.	J 1	21. Signature of Funeral Service	5 AM		4	Name and Address Barranco 195 Gov.	Ritchie .	Hwy. Se	verna Par	rk Funeral Home rk, MD 21146		
*	Incate be executed  Medical  Medical  X amineral  The private transit transit transit  The private transit trans	al Examiner	23a. Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if or heart shock is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	aused the deat ach line. (or as a conseq COPD (crass conseq (or as a conseq	Shore uence of):  Ushe (Ste	hea/	g, such as cardia		rest,	Approximate Interval Between Onset and Death		
. O. Box 68/60,	the death certificate y the attending phys iched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	1 ☐ Live t	come of pregna birth 2□ Feta nant at time of c own	Ideath 3□	Ectopic pregnance	у		23d. Date of Month			
ecords, P.	quires mat en signed b uld be deta	र्व	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1			
VITAI Meco	ctan: The law re ertificate has bee ctor, page 2 sho	Be Completed	25. Was case referred to medica examiner?	al				26. Place of Dea	24a. Was a autop perfor 1 Tyes ath (Check only or	sy prio med? dea 2 ☑No 1 □	re autopsy findings available or to completion of cause of th? IYes 2 □ No		
DIVISION OF	one nospital or Attending Prysician: The law requires that the death certification is once not oversafter death.  To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	1	not be	28d. Describe h	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	E nospital 24 hours : Funeral : etely filled	Medical Ce	29a. Certifier 1 ✓ Certifyi (Check only one) 2 ☐ Medical	ng Physician: To the in Examiner: On the base and many	best of my kno asis of examina ner stated.	wledge, death	occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manr	ner as stated. d due to the cause(s)		
	vithin To the compl	Me	29b. Signature and title of certifie		Q		29c. License	9566	:	29d. Date signed (/			
7,	42		30. Name and address of person	who completed caus	e of death (Item Medic	1 23a) (Type, F	Print)	Annapo	ics, ~	1D 212			
	Stat Registra		31. Date filed <i>(Month, Day, Year)</i>	6 2009 32. R	egistrar's Signa	ture <b>A</b> . <b>A</b>	bares	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TOAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimore Genesis Eldercare Randallstown 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 2, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** Maryland Days 1**X**M 2□F 33 218-94-8954 1976 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Maryland Carroll Westminster 1 XIYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 United States 775 Eagles Court, Apt. 3-C items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (M)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married black "natural", or 1 ☐ Yes 2 🛛 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) production technician manufacturing permit. Pages 1 and 2 should be filed wit Department of Heath and Mental Hygienn Important: If item 27 is marked other than any linjury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadie Floyd Richard D. Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
775 Eagles Court, Apt. 3-C Westminster, MD 21158 19a. Informant's Name/Relationship (Type. Print) 775 Eagles Court, Apt. 3-C Laurie Ann Logan - wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State St. Mark's (Snydersburg) Nov 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) v 13, 2009, Hampstead, Maryland Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home 934 South Main Street M01072 Hampstead, Maryland 21074 20 Mari 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 91000 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has by page 2 s certificate 1∐ Yes No. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 45Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3□ DOA P this 28a. Date of Injury (Month Day Year) funeral 27. Manner of Peath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: after death.

I Director: After din by the further. within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only

29b. Signature and time of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Dav. Year)

State Registrar

Medical

no 31. Date filed (Month, Day, Year)

NOV 10

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 10 2009 01:11 PM Elson Kaye Murrell /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 421 Razor Strap Road Cecil North East 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Bridge, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X** Months Hours 234-56-5500 74 **Director** 21,1935 Oregon Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director Maryland 1 □Yes 2√No Cecil North East 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? 21901 421 Razor Strap Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 → No Specify: þ Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress/Tailor Sewing IInknown Health and Mental Hygiem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Hnknown Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Omar Murrell / Husband 421 Razor Strap Road, NOrth East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State November Delaware Memorial Veterans Cemetery 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee 2009 Bear, Delaware 22. Name and Address of Facility Crouch Funeral Home WIS 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the div. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fulfure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin **Physician** enknown ung uncer disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ م 1 ■ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ∐Yes 2 🛛 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation n 24 hours atter uv..... he Funeral Director: A' 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific November 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Pamela LeClaire, MD, 102 East Cecil Avenue, North East, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 6 2009 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 191	Maryland /	Depa	rtment c	of He	alth ar	nd M	ental Hyg	jiene				
			State Registrar		Cert	tificate c	of De	ath		F	Reg. No	2009	3	3796	5
	Physicia	n/	1. Decedent's Name (First, Middle, Last)							2. Date of Dea		/ Year		3. Time of Death	
	Medic	al	Juan Manuel Molina							Novemb				12:30a N	1
	Examin	er	4a. Facility Name (if not institution, give street and number)  Manor Care-Silver Spring					scation of I			4c.	County of Dea		~~~~	
	Funeral			7. Age (In yrs. last birt	thdav)	If Under 1 Y		f Under 24		8. Date of Birth		Mont		ce (State or Foreig	-n
	Director		263-74-3090 XXM 2□F	96	Yrs.					(Month, Day,	Year)	913	Cul	oa Oa	1
			Usual Residence of Decedent												_
	yland -f sho ed at	ctor	10a. State 10b. County	10c. City, Tow									10d	. Inside City Limits	
	e Mar r 28a notifi	)ire	Maryland Montgomery  10e. Street and Number	Sil	ver	Spring			_					1 ☐ Yes 2 1 N	0
	ith th	ral	11405 Columbia Pike, A	nt Bl		10f. Zip Co		0904			10g. Citi	izen of What C US		?	
	ems	<b>Funeral Director</b>		lent Ever in U.S.	13. W	as Decedent			? (Spec	ify Yes or No-		14. Race - Am		Indian	
9	ter de or it	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 🗷 No	lf i	Yes, specify (	Cuban, I	Mexican, F	Puerto R	tican, etc.)		Black, Whi			
8	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	3 ☐xWidowed 4 ☐ Divorced If Yes, Give Year or Dat		1	X Yes 2	No 3	Specify:	Cub	an		Specify:		White	
<u>.</u>	72 ho "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	(Give ki	ent's Usual Oc nd of work do	ne duri		f workin	9	16b. Ki	nd of Business	Indus	stry	
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<u>la</u>	d be f Aenta arked tic ev	욘	Matias Molina					Mar	ria	Luisa R	lang	el			
, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-f short item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Robert Molina/Son	19b						Route Number,					
Baltimore,	e 1 and of Heal of Heal if item ?		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from \$	20b. Place o		ition (Name of atory or other				ate	20c. Lo	cation - City o	r Town	, State	_
Ē	Page 1 tment of 1 tant: If it jury or o		4 Donation 5 Other (Specify)	Met	ropo	litan	Cre	mator	th <sub>NO</sub>	2009	Ale	xandria	١, ١	/irginia	
Ra	permit. Page 1 Department of Important: If is any injury or o	6 m	21. Signature of Funeral Service Licensee	mo1503	3 22 F 5	rancis 00 Uni	ver	f Coll Sity	lins Blv	Funera d. W.,	l Ho Sil	ome Inc ver Spr	ing	g, MD 209	90
		ñ	23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac	used the death. Do r h line.	not enter	the mode of	dying, s	such as car	rdiac or	respiratory arre	est,			pproximate terval Between	
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	Medical Examiner			r as a consequence o	of):										
		ner	Sequentially list conditions, if any, leading to immediate b. Arrhythmia  Due to (or as a consequence of):								-				
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7. Ö.	that the ned be deta	by P	Part II. Other significant conditions contributing to dea	ath but not resulting i	in the un	derlying caus	e given	in Part I.		23e. Did tob	oacco us	se contribute to	o the c	ause of death?	
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Vital Records,	aw rec as bee 2 sho	Completed								24a. Was ar				findings available letion of cause of	
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<u>a</u>	cian: ertific ector,	Be (	25. Was case referred to medical examiner?					of Death (	(Check c						
<u> </u>	Physic this c	은		patient 2 ER/Ou		3 LI DOA				e 5 🗆 Reside			cify)		
Ion ot	tending leath. or; After the funer	Certificate:			Time of njury	v	njury at /ork? Yes	s 2 □ No	- 1	3d. Describe ho	w injury	occurred			
DIVISION			4 Homicide determined 28e. Place of building						City or Town	ocation (Street and Number or Rural Route Number, Sity or Town, State)					
	the Hosp in 24 hou the Funer apleted fil	Medical	29a. Certifier (Check 2 Medical Examiner: On the besis only one) 3 Certifying Nurse Practioner: To	of examination and/o	or investic	iation, in my oi	oiníon. c	death occur	rred at th	ne time date and	d place	and due to the	called	s) and manner stat	ed.
þ	or with		29b. Signature and title of certifie		29c. License number 29d. Date signed (Mon										
			30. Name and address of person who completed cause			,									
				Darnestor	wn R	oad, #	202	, Gai	the	rsburg,	Mđ	20878			
	Stat Registra			istrar's Signature	1	arked									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 Day 04 Physician/ Melvin Floyd Markey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 04/09/192 **Director** 82 196-20-6047 Usual Residence of Decedent 28a-f show thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2413 Belair Drive 20715 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed 1945-46 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+Aeronautical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Charles Markey Anna Marie Prager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Frances P. Markey/Wife 2413 Belair Drive, Bowie, Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🔲 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other place) 11/7/09 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown as been signed by the 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director; After this certificate has be autopsy performed Yes 2 page 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 MInpatient 1 Yeş 2 🗹 No ဂ္ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Yea 09

4:30 P.M

9. Birthplace (State or Foreign

10d. Inside City Limits

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3 ☐ Probably 4 ☐ Unknown

Month

death? 1 Yes 2 No

Registrar DHMH 17 Rev 7/2009 Name and address of per-

cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** MAZIEMO 11 2009 M. Marides -ouise 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 10 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Ye*ar)*929 Maryland 1 □ M 2 1 F 80 218-32-6334 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Inductant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once. 1 ☐ Yes 2 No Maryland Anne Arundel Davidsonville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21035 USA 3437 Riva Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Black <u>≥</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None Homemaker 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Stepney William H. Green ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3437 Riva Rd. Davidsonville, Md. Richard Moulden (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran | 11-9-09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mame Reades of Sacilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 H. Leese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute rea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dehanctio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day Year Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No After this certificate has funeral director, page 2: 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 I ER/Outpatient 3 I DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death spltal or Attending Prous after death.
neral Director: After y filled in by the funer. Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier were, 02/20 0002053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37968 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2009 6.00 by Edwin Nelson, Jr. Harvey 4b. City, Facility Name (If not institution, give street and number) Town, or Location of Death County of Death oastal aliskur at the C Q comico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours 217-52-2316 2-13-1948 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Aydelotte Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cabinet Maker Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Edwin Nelson, Sr. Elva Milbourne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Nelson - Wife 101 Aydelotte Road, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery 11-9-2009 | Pittsville, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician /Medical Examiner

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Funeral

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**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland

of Health

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercities in ust by training at

Physician/Medical Examiner þ Completed Be Certification: To

s certificate has b irector, page 2 st

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

Immediate Cause (Final disease or condition resulting in death)	a. Metwatical Due to (or as a consecutive of the co	Junerce of):	tic Cana	M	Onset and Ceath			
Sequentially list conditions, if any leading to include lying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect  Due to (or as a consect  d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fets 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopic p	regnancy ecify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying o	ause given in Part I.		o use contribute to the cause of death?			
				24a. Was an autopsy performed?				
25. Was case referred to medical			26. Place of De	eath (Check only one)				
examiner? 1 ☐ Yes 2 No	Hospital: 1 mpatient 2	ER/Outpatient 3 D0	Other: 4 Nursing	Home 5 ☐ Residence	6 ∏Other (Specify)			
27. Manner of beath Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) n		8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in				
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)			, office	28f. Location (Street City or Town, Sta	Street and Number or Rural Route Number, vn, State)			
29a. Certifier (Check only one)  Certifying Pl	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and pla , in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)			
29b Signature and title of certifier	M	290	: License number	29d. I	Date signed (Month, Day, Year)			

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Concall filed (Month, Day,

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:00 am Ly Thien Nguyen 2009 03 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign Country) Vietnam 8. Date of Birth (Month, Day, Year) 10/26/1946 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Months Min. 1 M 2 □ F Days Hours 461-90-4378 Director 63 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examinar must be mathered once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 X No Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20903 U.S.A. 1320 Stateside Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MCRD Desk Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Trinh Phan Unknown ပ Nauyen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1320 Stateside Drive, Silver Spring, Maryland 20903 <u> Tam Minh Nguyen - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral ervice I 22. Name and Address of Facility Hines-Rinaldi Funeral Home, ichele 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 X No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director; After it completely filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 03. 2009 2 H0064588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashish Tolia,

NOV

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31. Date filed (Month, Day, Year)

D.O.,

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Forest Glen Road, Silver Spring, Maryland 20910

			Plea	se Type or Pri							egible.	
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			Registrar  1. Decedent's Name (First, Middle)	e, Last)	-		uncate or	Dealli	2. Date of D	Reg. No.	2009	3. Time of Death
	hysici Medic		George Edmund	·					Month Novem	ber 6,	Year 2009	9:45 a <sup>M</sup>
-	xamir		4a. Facility Name (If not institution	, give street and number	)		4b. City, Town,	or Location of Deat	h	4c. C	ounty of Deat	h
April			Montgomery Ger  5. Social Security Number			ast birthday)	Olney If Under 1 Year		8. Date of B	irth		fontgomery  hplace (State or Foreign
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pui	2		Usual Residence of Decedent  10a. State 10b. County		100 City	, Town or Lo	antion					10d. Inside City Limits
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5-0036 72 hours after death with the Maryland	ouer than natural, or tems 23a of 28a-1 snow event, the Mydigal Evaniang must be notified at	by	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2 □ Yes 1 f Yes, Give Year or Dates:	INO		I□Yes 2☐No	Specify:		S	pecify: Whi	te
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Maryla 2 should 1 and Mer	traumatic		19a. Informant's Name/Relations		-		-			-		Zip Code) 20906
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Saltimore, Maryland bernit. Pages 1 and 2 should be file Department of Health and Mental Hy modular: If them 27 is marked of the	y Injury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service		nţ	_Cemet		ess of Facility COllin	009 5. Euror			
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<b>BOX</b> sath cer	for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pregnan	cy -		230	d. Date of del Month	ivery Day Year
the d	ched	Jysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of de	eam 5L	Other (specify)					·
S, T	e deta	by Pi	Part II. Other significant conditio	ns contributing to death b	out not resul	Iting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Ord require een si	ould b								1 🗆	Yes 2	No 3□ Pr	obably 4 Unknown
records, te law requires t that been signer	Je 2 st	Completed							24a. Was	ppsy	prior to o	topsy findings available completion of cause of
VILAI I Ician: Th certificate	or, pag	ပ္ပ	25. Was case referred to medical	-					1 □ Yes	ormed? 2 No	death? 1 ☐ Yes	2 No
yslcie	direct	00	examiner?	Hospital: 1 ☐ Inpati	ent 2XE	R/Outpatien	t 3 DOA Ot	26. Place of Dea her: 4 ☐ Nursing H	atn ( <i>Cneck only</i> Iome 5 ☐ Res		Other (Spec	cify)
ing Phy	ıneral	C:Uo	27 Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Inju		28d. Describe			
Attending ar death. ector: Afte	the f	icati	2 Accident investig	ot be Rhos of In	uru - At hor	ma form etre	M 1 E	]Yes 2 □ No —————	OOA Location	/Ot 1 1	1 - 1 2	15
al or A	d n b	Certification: To	4 ☐ Homicide determi	building, ei	c. (Specify	)	eet, factory, office		City or To	(Street and r Iwn, State)	vumber or Hu	ıral Route Number,
UNIVISION OF INCLUDED TO THE HOSPITAL OF THE LAW HEAD TO THE HOSPITAL OF Attending Physician: The law requires that the death within 24 hours after death. After this certificate has been stoned by the attent of the function.	tely fille		Check only 2 Megical i	g Physician: To the best Examiner: On the basis of	ot examinati	vledge, death	occurred at the treatment occurred at the treatment of th	time, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) a	nd manner as ace, and due	s stated. to the cause(s)
o the lithin 2 the lo the	отріе	Medical	29b. Signature and time of certifier	and manner st	ated.	0	29c. Licen				igned (Month	
1.	0		1 Mondo	Model	4. W.		DIL	458		NN/o.	2419	9
/0			30. Name and address of person v	who completed cause of	enh (Item	23a) (Type, I	Print)	21	_ 51	V. T. C	IA	Apucado
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	rar's Signati	ure R	reoken	À AVENUC	- JIW	Ch Th	104 11	MKYLKINE)
Re	egistra	ır	MUA ()	9 2009 Sen	wa	p. A	arks					

Robert Henry Osborne State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 8, 2009 1623 hrs Medical Examiner Robert Henry Osborne 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Union Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 6. Sex If Under 1 Year Funeral Foreign Months Days Hours Min Director 184-42-0448 57 11/05/1952 Country) PA 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Maryland Cecil E1kton 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number ā 55 Elk Hill Ct. 21921 USA 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. 1 Never Married 2 X Married Armed Forces' 2 X No Yes I. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygene. Trant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examine. Widowed Divorced Yes, Give Year Yes 2 X No specify: Specify: White ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Retail Clerk Convenience Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Osborne Hazel Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara A. Osborne/Wife Elk Hill Ct., Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation -11-2009 crematory or other place) Removal from State R.T. P.A. Foard Funeral Home, Rising Sun, Maryland Donation 5 Other Specify 22. Name and Address of Facility
R.T. Foard Funeral Home,
111 S. Oueen St., Rising f Funeral Service Licens Queen St., Rising Sun. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease yaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED ending physician use as the burial The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) has been signed by the att 2 should be detached for 1 Yes 2 No 9 Unknown q Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? page ✓ Yes 2 2 No 1 V Yes 26.Place of Death (Check only one) Hospital or Attending Physician; 25. Was case referred to medical director, Division of Vital Be examiner? Hospital: 1 Other 4 Inpatient 2 V ER/Outpatient 3 DO4 Nursing Home 5 Residence 6 Other After this 2 1 V Yes funeral of 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot self FOUND: Natura t 24 hours after death.

Funeral Director: A etely filled in by the fu Yes 2 V No Pending Nov 8, 2009 1514 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 55 Elk Hill Court, Elkton, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal within 2 To the I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29b 29d. Date signed (Month, Day, Year) **€**igna O.C.M.E. November 10, 2009 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) Day 32. Registrar's Signature State rack knua

Registra

OCME

Baltimore, Maryland 21215-0036

P.O. Box 68760.

of Vital Records.

Division

			Tor State of Maryland'/ De Registrar	partment of F ertificate of I	lealth and	Mental Hy	giene 2009	37973
	Discortin		Decedent's Name (First, Middle, Last)		Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physic /Medi		James Frank Orzolek			Novemb	per 09 200	09 0855 м
	Examir	ner	4a. Facility Name (If not Institution, give street and number)  Carroll Hospice Dove House	4b. City, Town, or Westmi		th	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h a Ri	rthplace (State or Foreign ountry)
	Director		215-50-6365 X M 2 F 56 Yrs.	Months Days	Hours Min	April (	04°1953	MD
	/land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	e Mari	ctor	MD Carroll Westmi	nster				1 □Yes 2 No
	vith th	Dire	10e. Street and Number	10f. Zip Code			10g. Citizen of What C	ountry?
	ns 23a	Funeral Director	3153 Cardinal Drive  11. Marital Status   12. Was Decedent Ever in U.S.   13	211		Specify Vac or No.	USA 14. Race - Am	Orloon Indian
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exp., it will be notified at		Armed Forces?  1 □ Never Married 2 □ XMarried   1 □ Yes 2 □ XMo   1 □ Yes 2 □ XMo   1 □ Yes 2 □ XMo   1 □ Yes 2 □ XMo   1 □ Yes 3 □ XMo   1 □ XMo	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> <li>1 ☐ Yes 2 ☐ No</li> </ol>		to Rican, etc.)		erican Indian, te, etc.
21215-0036	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify:			Mite
215	e. un "na"	Completed	(Specify only highest grade completed) (Gin	cedent's Usual Occupa ve kind of work done o v. DO NOT use retired	ation during most of wo f)	rking	16b. Kind of Business State of M	laryland
2	filed witl Hygiene other tha	Com	2 Vo	cational I			Correction	IS
Maryland	i be fill ed oth ed oth	Be	17. Father's Name (First, Middle, Last)  Frank Bernard Orzolek				Maiden Surname)	
ary	2 should be f and Mental I is marked of aumatic eve	To		iling Address (Street a		ine Mulli ural Boute Numbe	LN  or, City or Town, State,	Zin Cade)
Š.	1 and 2 Health a em 27 is	1.5		53 Cardina				21157
Baltimore,	Pages 1 nent of Hi int; If iten iry or oth		20a. Method of Disposition  1 □ Burial 2 □ ★ remation 3 □ Removal from State  20b. Place of Disposerery, or	position (Name of ematory or other place	e)	Date	20c. Location - City or	·
Ξ	permit. Page Department of Important: If any Injury or once.		4□Donation 5□Other (Specify) Carroll				Hampstead	*
Ra	Depi Impo any		Lake Kall	Pritts Fun	ieral "Hon	ne and Ch	apel, P.A. minster, MC	21157
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying	g, such as cardia	c or respiratory an	rest,	Approximate Interval Between
and the	Physician	9	Immediate Cause (Final disease or condition resulting in death)	Carcen	m			Onset and Death  OS(11/04 + 0 11/9/1)
	/Medical Examiner	П	Due to (or as a consequence of):					
	T +	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	ecuter and transi	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C					
8760,	ficate be executed physician and s the burial-transit		Due to (or as a consequence of):					
20	tificate ig phys as the	ledical	d					
X O D	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy	,		23d. Date of de	
5	he dea / the a shed fo	ysici		Other (specify)			Month	Day Year
τ <u>.</u>	ires that the de signed by the be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	n in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Spros	en sig					1 □ Y€	es 2 □ No 3 □ P	robably 4 Unknown
2	law re has be	Completed				24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
ב כ	ding Physician: The law h. Affer this certificate has b funeral director, page 2 s					perform	med? death? 2 □ 1 □ Yes	· ·
5	rsiciar s certif lirecto	Be	25. Was case referred to medical examiner?  1   Yes   2   Mo	Othor		th (Check only on	11	0 - 1 - 1
5 1	ng Phy ter this neral c	2 : Lo	27. Manner of Death 28a. Date of Injury 28b. Time	ant 3 LI DUA	4 LI Nursing H	ome 5 ☐ Reside	ence 6 Other (Spe	city) DOVE how
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	tendir leath. tor: Af the ful	catic	11 ☐ Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		? ′es 2 □ No			
5	after d after d Direct I in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (St City or Town	treet and Number or Ri n, State)	ural Route Number,
	ospita hours ineral y fillec		29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea	th occurred at the tim	ne, date and place	and due to the c	ause(s) and manner a	s stated.
	the Ho nin 24 the Fu npletel	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my op	pinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
į	5 th 6 0	2	29b. Signature and title of certifier	29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
	NATIE	-	30) Name and address of person who completed cause of death (Item 23a) (Type,	Print)	64597		11/4/0	1
~	SILL		MORE L. Rice 555 South Cater		POSTHING	STO IMD	21157	
	Stat	~	31. Date filed (Month, Day, Year)  32. Registrar's Signature	backer				
	Registra	1	NOV 1 0 2009 Anus B. A					

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ene 1. No. 2009	37974
ı	Physic		Decedent's Name (First, Middle, Last)     Ann Graham Perry		2. Date of Death Month Nov • (	Day Year 2009	3. Time of Death
in f	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
, e <sup>y</sup>	Funeral	7	3502 B1ue Ball Rd。  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	Ceci1	place (State or Foreign
	Director		200-22-9624 1□M 2☒F 79 Yrs.	Months Days Hours Min.	July 29,	1930 Per	nnsylvania
	yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	he Ma	Director	Maryland Cecil Elkt				1 ☐ Yes 2 🔀 No
	h with		3502 Blue Ball Rd.	10f. Zip Code 21921	10g	. Citizen of What Cou USA	ntry?
	er deat Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examinar must be notified at	by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify: W	hite
15-0	n 72 ho "natus	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16l	b. Kind of Business/Ir	idustry
212	d withii giene. er than , in e M	Somp	Elementary/Secondary (0-12) College (1-4or 5+) Home	maker		Own Home	
and	d 2 should be filed within 72 hours after death with the Marylan than Mental Hygiene. 71 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	den Surname)	
aryl	2 should be f and Mental Is marked of aumatic eve	2	Harper Graham  19a. Informant's Name/Relationship ( <i>Type. Print</i> )  19b. Maili	Opa1 W ling Address (Street and Number or Rur		ity or Town, State, Zi	p Code)
S,	es 1 and 2 of Health a f item 27 ls r other tra			2 Blue Ball Rd., E			4
10 1	Pages 1 nent of I: ant: If ite ury or ot		Popular 2 - Cremation 3 - Removal from State	osition (Name of ematory or other place) 11-14 on Memorial Park Ce	+-2009	c. Location - City or To	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.			22. Name and Address of Facility, R.T. Foard and Jo			, Delaware
ь	20 <b>5 6 6</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	122 S. Main St.,	Newark, D	DE 19711	A
∖.F	Physician /Medical		shock, otheart failure. List only one cause on each line.  Immediate ause (Final disease condition resulting in death)  Due to (or as a consequence of):	y colon	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	Į.	Sequentially list conditions, if any, leading to hymodiste  Due to (or as a consequence of conse	0			
	nd nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
8/60,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last  Due to (or as a consequence of):				
200	ng phys	Medical	d.		10.0		
מ מ	attendi for use	Physician/Me	In the past 12 models:	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
ָר ס	by the	hysi	9 Unknown				
ecords,	within 24 bounds after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobac	co use contribute to t 2 ► No 3 □ Prof	he cause of death?
Sec	e has b	Completed			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
VIIAI	ertificate	Be Co	25. Was case referred to medical	26. Place of Deatl	1 □ Yes 2 ☑ h (Check only one)		2 □ No
	this ce	၉	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien			e 6 □Other (Specia	fy)
5 5	ath. r: Affer e funer	ation	27. Mann, of Death 1 7 Natural 5 ☐ Pending 2 Naccident investigation  28a. Date of Injury (Month, Day, Year) Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how is	njury occurred	
	s after des Il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
Hoenit	e Funera letely fille	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, avestigation, in my opinion, death occurrence.	and due to the caus red at the time, date	e(s) and manner as and place, and due to	stated. o the cause(s)
Ę	within To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			Middential J.V.	C2 000 2000	DE.	11/9/09	7
			30. Name and address of person who completed cause of death (Item 23a) (Type, Nicholas Biasotto, M.D., 620 Stanton		Suite 205	. Newark	DE 19713
	Stat Registra	te ar	31. Date filed (Month, Day, Year) 2 2009  32. Redistrar's Signature	bark			

Division of Vital Records, P.O. Box 68760, 24 hours a within 2 To the I

(Check only one)

29b. Signature and title of certifier

- Kouarchou, mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature Barker

State

29c. License number

263746

29d. Date signed (Month, Day, Year)

November 11, 2009

			For State		State of Ma	aryland	-		of Heal of Dea			giene Reg. No.		_	07076
			Registrar  1. Decedent's Name	(First, Middle, Last)	)			imoun			2. Date of De	ath	<b>ZUU</b>	9 3.	Time of Peath
	Physicia /Medic		ROGER	Α.	SCHERFF					N	Month OVEMBER	Pay 5	200		.935 <sup>M</sup> _
	Examin		4a. Facility Name (If	not institution, give	street and number)			4b. City,	own, or Loca	ation of Death		1	County of D		
				GENERAL		- //	and the fresh admired	BEI If Under	LIN	Inder 24 Hrs.	8. Date of Bir		VORCES'		(State or Foreign
	Funeral Director		5. Social Security Nu 154-03-46	117	₹M 2□F	e (in yrs. ia: 37	st birthday) Yrs.	Months		ours Min.	JAN. 25	y, Year)		Country) W JEF	
	pur &		Usual Residence of I	Decedent 10b. County		10c. City.	Town or Lo	cation						10d.	Inside City Limits
	f sho	5	DELAWARE	SUSSEX	7		ICK IS								1 <b>X</b> Yes 2□No
	n the Maryland r 28a-f show	Director	10e. Street and Num		7	T LIVY.	IOK II	10f. Zip	Code			10g. Citi	izen of What	Country?	
	23a or	a D	28 W. ES	SSEX ST.,	EXT.			19	944			US	SA		
	Items 2	ıner	11. Marital Status		12. Was Decedent 8 Armed Forces?	ever in U.S.	. 13.	Vas Deced	ent of Hispan ifv Cuban, Me	nic Origin? (Spexican, Puerto	pecify Yes or No Rican, etc.)	)-	14. Race - A Black, W		ndian,
336	a o E	by Funeral	1 ☐ Never Marrie	**	1 Mayes 2 ☐ Note 1 Mayes 1 Mayes 2 ☐ Note 1 Mayes 2 ☐ Note 2 ☐ No	wwII		I∐Yes 2		ecify:	,		Specify:	WH]	TE
altimore, Maryland 21215-0036	"natural",	Completed	(Speci	15. Decedent's Edu ify only highest grad	cation e completed)		16a. Dece	tent's Usua	l Occupation	g most of work	king	16b. Ki	ind of Busine	ess/Industr	ry
72.	l within giene. r than	dmo	Elementary/Secon		College (1-4or 5	+)			SIOLO			FI	EDERAL	GOVI	ERNMENT
P P	il Hyg other /ent,	Be C	17. Father's Name (	First, Middle, Last)					18.	Mother's Nam	e (First, Middle	, Maiden	Surname)		
/lar	uld be Menta arked	70 E	GEORGE	SCHERF	7					FLORE		ORGA			
Mar	2 sho			me/Relationship (T)				_	•		ral Route Numb				
e,	1 and Healtt em 27 ther ti		MARY R. S	SCHERFF/W	LFE	20h Pla	ace of Disno	sition (Nan	ne of		FENWICK Date		ocation - City		
mor	Pages nent of int: If ite		1 □ Burial 2 5	Cremation 3 ☐ F     ☐ Other (Specify)	Removal from State	ce	metery, crer	natory or o	her place)	A 11/7	7/09		MAR, D		
3alti <sub>l</sub>	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, Inoce.		21. Signature of Full			ORLI	22	. Name an	d Address of	Facility					
ω	20 E # 9		· Ch	aly N	Mary	1					OME, SEI		ILLE,		proximate
			23a. Part 1. Enter the shock, or hear Immediate Cause (I	ne disease, or compl rt failure. List only o	ne cause on each li	i the death. ne.	. Do not ent	1		ich as cardiac	or respiratory a	inest,		Int	erval Between set and Death
1	Physician /Medical		disease or condition resulting in death)	n e	a. Due to (or as	a conseque	en v of):	461	0715					4	eary_
23	Examiner				540 10 (01 40	a consequ									
7: [	D ti	iner	Sequentially list con it any leading to improve cause. Enter Under Cause (Disease or it that initiated events	nditions, mediate rlying	Due to (or as	a conseque	ence of):								
Too	ificate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) L		c Due to (or as	a conseque	ence of):							-	
72 T 68760,	e be e sician buria	al E			d		,								
77	tificate g phy as the	edical			u							-			
30 CC 2/2	eath certifi attending for use as	an/M	23b. Was decedent in the past 12	pregnant	23c. If yes, outcome 1 \subseteq Live birth	2 🗀 Fetal	death 3[	⊒ Ectopic p					23d. Date of	f delivery Da	y Year
152	the d y the ched	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	it time of de	eath 5	Other (sp	ecify)						
800	s that	by Pr	Part II. Other signifi	icant conditions co	ntributing to death b	ut not resul	Iting in the u	nderlying c	ause given in	Part I.	23e. Did	tobacco			ause of death?
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4 E											1 □ Yes			Yes 2[	□ No
er /	Physician: r this certific ral director, p	Be	25. Was case referr examiner?		Hospital:	ant 0 🗆 1	ER/Outpatie	at 2 🗆 D	Othori		ith <i>(Check only</i> Iome 5 ☐ Res		€ □Othor /	(Considu)	
000	Phy r this	n: To	27. Magner of Death	h	28a. Date of Inju	ıry	28b. Time o		8c. Injury at Work?	I □ Nursing H	28d. Describe			<i>Specily)</i>	
X 0 io	Attending Fride triangle of the funeral of the fune	atio	1 Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	iy, rear)	Injury	М		2 □ No					
Pt-	spital or Attencours after deatheral Director:	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At hor c. <i>(Specify</i>	me, farm, sti	eet, factory	, office		28f. Location City or To			or Rural R	oute Number,
030	Hospital 24 hours a Funeral I		29a. Certifier (Check only	Certifying Phy	/sician: To the best iner: On the basis o	of my knov	vledge, deat	h occurred	at the time, o	date and place	e, and due to th	e cause(s	s) and mann	er as state	ed.
25	the the	Medical	one) 29b. Signature and		and manner st				c. License nui		an ou at the time		ate signed (A		
	o viit	_	Lab. digitature and	14911	ul			F	728	76e	7		11/6	69	
	12/2		30. Name and addre	ess of person who o	ompleted cause of	death (Item	23a) (Type,	Print)	0-	JANI	1		1-	1 1	No imalial
	200	•	31. Date filed (Mont	tb. Day. Year)	32. Registr	rar's Signat	ure )	201	08%	rel Her	uney 6	lu	101 -12	Herry	NE 19944
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9:35 AM 2009 phyaax /Medical City, Town, or Location of Death c. County of Death Facility Name (If not institution, give street and number) Examiner Hrund UNMO OC andrin MMe 8. Date of Birth (Month, Day, Aug 31, If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔏 Days Hours Min 1956 576-84-9834 Virginia Director 53 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the "Marked Examinating the natified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Prince George's Upper Marlboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 USA 9744 Wyman Way by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 []Yes 2 []XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bank Manager Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Thomas Wilkinson Bertha Marie Lufsey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack E.Shugarts/husband 9744 Wyman Way Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 11/12/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YeyRs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 200 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Auther (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Director A investigation 1 ☐ Yes 2 ☐ No fter death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) of person wit

State Registrar

30. Name and addres

Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pearl Virginia Tolbert 2009 a.M 5:32 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 22 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Months Days Hours Min. 230-24-7251 88 Director Aug. Virginia Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Cecil Port Deposit 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 274 Doctor Jack Road 21904 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Brickey Maxine Price of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Tolbert (son) Baltimore. Kimble Road. Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1 and Department of Inportant; If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/09 Glade Spring, Virginia Mt. Rose Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sign re of Funeral Service Licensee Name and Address of Facility & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final failur Physician/ disease or condition resulting in death) idney Medical Due to (or as a consequence of): Examiner End-Stace Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conseq nce of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 V certificate has been signed by the irrector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available 24a. Was an Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical

within 24 hours after deat To the Funeral Director:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2149194 November 10,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles MD 21204 Touson.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

31. Date filed (Month, Day, Year)

NOV 1 2 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 1:00 P.M Vernon Woodrow Tome 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PERRY MARYLAND HEALTH CARE SYSTEM PUINT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Porting Deposit Maryland Months Days 219-07**-**3905 Nov. 1, 1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Cecil Rising Sun 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1568 Theodore Road 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Dyes 2 No Army Hyes, Give Year or Dates: 1942-46 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Technician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Tome Ella MacCauley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon D. Tome / Son P.O. Box 594, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hopewell Cemetery 18, 2009 Port Deposit, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death N Immediate Cause (Final disease or condition resulting in death) CORONARY ERY -ALSEASE Due to (or as a consequence of): PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELLITUS 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

**Examiner** 

**Funeral** 

Director

28a-f show

Director

by Funeral

Completed

Be

2

if than "natural", or items 23a or 28a-f shout the Wedley Examinating the position of

realth and Mental Hygiene.
m 27 is marked other than "er fraumatic ever

permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is mark any Injury or other traumati once.

KNOWN TO PHYSIEIAN: VERNON

Baltimore, Maryland 21215-0036

certificate be executed sician and burial-trans attending physician for use as the buria

P.O. Box 68760

Division of Vital Records,

the certificate this After **Hospital or Attending** death.

Examir in by the funeral ithin 24 hours after death.

the Funeral Director: A

ompletely filled in by the fu

Completed Certification:

Medical

Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

ADRTIC STENASIS

24a. Was an perform 1 □Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 😿 No

27. Manner of Death 1 X Natural 2 Accident

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1. Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. edical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time, date and place.

(Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

D24648

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHER A: NASHMI, M:A:, VA MARYLAND HEALTH CARE SYSTEM, RERRY POINT, MD 21402 31. Date filed (Month, Day, Year)

State Registrar

within 7

				State of Maryland / Dep		Mental Hygie	ne	
			1 - State Registrar	Ce	rtificate of Death	Reg.	No. 2009	37980
	Physic	an	Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year	3. Time of Death
-	/Medi	cal	Martha	F.	Twilley	11 0		8:00 PM
	Exami	ier	4a. Facility Name (If not institution, give sti	-n /	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Wi Co	ace (State or Foreign
	Director			vi 2∏ F 86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 9-6-1923		fry)
			Usual Residence of Decedent	00		9-0-1923	Mary	vland
	rylan ihow	_	10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits
	e Ma Ba-f s	cto	MD Wicomic	o Hebron				1 □ Yes 2X No
	iff th	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	ry?
	ath w	ra	25789 Rewastico Roa		21830		USA	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evaniment to notified at	Funeral		. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∐Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🌠 No Specify:			ite
ŏ	2 hou	pe	15. Decedent's Educa		dent's Usual Occupation	16b	. Kind of Business/Indo	netry
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2	d with giene	ě	12	College (1-4or 5+)	istered Nurse		Medical	
p	e filed y al Hygid other	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
<u>a</u>	should be fand Mental I s marked of tumatic ever	2	Claude A	. Twil	ley Eliza		Hollaway	,
Maryland 21215-0036	2 sho and is me		19a. Informant's Name/Relationship (Type	. Print) 19b. Mailii	ng Address (Street and Number or Ru	al Route Number, Cit		
≥,	s 1 and 2 should I of Health and Men item 27 is marke other traumatic		David S. Twilley -	Son 9881	Sharptown Road, 1	Mardela Sp	rings. Mar	vland 2183
Baltimore,			20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ Ren	20b. Place of Dispo	sition (Name of matory or other place)	Date 20c.	Location - City or Tow	vn, State
ᆵ	. Рад tmen tant:		4 Donation 5 Dother (Specify)		1 Memory Gds: 11-1	3-2009 н	ebron, Mar	yland
ğ	permit. Page Department of Important: If any Injury or once.	1	21. Signature of Funeral Service kicensee	. 21 /- 22	2. Name and Address of Facility Bo	ounds Fune	ral Home	
_	⊕ □ = # O		1/felisso Herry		05 E. Main Street	, Salisbur	y, Marylan	d 21804
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not ent cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	CARDIOMYO	PATHY RN	D STAG	CAR "	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
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0/2 0/2	ficate be executed physician and s the burial-transit	edical	d					
ğ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Funeral Directorer. After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit							
ŏ	th cer tendir r use	Physician/M	200. Was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Testania svessom		23d. Date of deliver	у
7.	e dea he af ed fo	sicis	in the past 12 months? 1 ☐ Yes   No		Ectopic pregnancy Other (specify)		Month D	Day Year
ŗ	at the	Phy	9 🗆 Unknown					
'n	res th	ক্র	Part II. Other significant conditions contrib	outing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
ecords,	requi	ted			<u> </u>	1 ☐ Yes	2⊟No 3□ Proba	bly 4 Unknown
ັ້ລ	e law has t	Completed				24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of
2	t The	ပွဲ				performed	b   death?	EH6
<u> </u>	ician certif ector	Be	25. Was case referred to medical examiner?	nital:		(Check only one)		
5	Phys	은	1 168 20 100	1 ☐ Inpatient 2 ☐ ER/Outpatien		me 5 Residence	1 27	HOSPICE
5	ding h. After fune	<u></u> 등	1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day, Year) Injury	Work?	28d. Describe how in	jury eccurred	
2	Atten deat ctor: y the	lica	2 Prioride 6 Could not be	28e Place of Injury - At home, farm, etre	, , , , , , , , , , , , , , , , , , , ,	206 ( 2221) 27 (24		
3	after after Dire d in b	Certification:	4 ☐ Homicide determined	<ol> <li>Place of Injury - At home, farm, streeth building, etc. (Specify)</li> </ol>	set, lactory, office	City or Town, Sta	and Number or Rural I ate)	Houte Number,
	spita nours neral / fille		29a. Certifier 12 Certifying Physici	an: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause	a(s) and manner as sta	ted
	n 24 h	Medical	(Check only 2 Medical Examiner one)	On the basis of examination and/or invand manner stated.	estigation, in my opinion, death occur	ed at the time, date a	and place, and due to the	he cause(s)
	Vithii Comp	ž	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, Da	ay, Year)
1	12		1/8		D0858410		11/05/00	9
	VCA!	t	30. Name and address of person who comp	leted cause of death (Item 23a) (Type, F	Print)			<u>'</u>
	IN		6 Huyan wang	PO BOX 177	1)0058410 Print) SACSBU	up a	11/08/0°	2
	Stat	~	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Registra	r	NOV 1 0 2009	Deneur D. A	arker			

	for State Registrar	tate of Maryland /	Department of F		ntal Hygier Reg. I	ne No.2009	37981
	Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
ysician	MARY IRMA TRU	ITT		N	Month I	7 2009	0545 м
Medical xaminer	4a. Facility Name (If not institution, give stree		4b. City, Town, o	r Location of Death		4c. County of Death	_
	ATLANTIC GENERAL HO	SPITAL	BERLIN			WORCESTE	
ineral	5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last b	I Months I Davs	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	ar) Coui	place (State or Foreign
ector	213-16-7244	90	Yrs.		T. 19,	1919   MA	RYLAND
	Usual Residence of Decedent  10a. State 10b. County	10c. City. Toy	vn or Location			1	0d. Inside City Limits
once.  To Be Completed by Funeral Director	,		OPVILLE				1 □Yes 2X No
jo O	ARYLAND WORCESTER  10e. Street and Number	DISH	10f. Zip Code		10g.	Citizen of What Cour	ntry?
₫	10750 CF MADELLIC N	TECK DOAD	21813			USA	
Funeral	10/59 ST. MARTINS N	Was Decedent Ever in U.S.		dispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	14. Race - Americ	
핊	1 Never Married 217 Married	Armed Forces?			an, etc.)	Black, White,	
2		f Yes, Give 23 Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: WHI	LE
Completed	15. Decedent's Education (Specify only highest grade control		a. Decedent's Usual Occup	pation during most of working	16b	. Kind of Business/In	dustry
宣		College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)		OWN HOME	
Son	12		HOMEMAKER		Time Adjusted - Admir		
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (F FLORENCI			
ဥ	EDWARD COLLINS			L			- Code)
	19a. Informant's Name/Relationship (Type. I		b. Mailing Address (Street				
	JOSEPH C. TRUITT/HUSI					. Location - City or To	
	20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Remo	oval from State	of Disposition (Name of ery, crematory or other pla	1 .		-	
	4 □ Donation 5 □ Other (Specify)	BISHOP	VILLE CEMETE 22. Name and Addre		/09 BIS	HOPVILLE,	MD
1	21. Sign dure of Funeral Service Licensee	A		UNERAL HOM	F SELRY	VILLE, DE	19975
once	23a. Part 1. Enter the disease, or complication	and the during the death. Dr					Approximate
	shock, or heart failure. List only one ca	ause on each line.					Interval Between Onset and Death
ı	Immediate Cause (Final disease or condition resulting in death)	unidary	TRACT 1	VFECIL	4		
		Due to (or as a consequence					
ē	Sequentially list conditions,			1	988		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Coneran	gracent.	/treener	NO		
Exa	resulting in death) Last	Due to (or as a consequence					
cal	d						
led	I SERVICE						
an/N	23b. Was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 ☐ Ectopic pregnan	cy		23d. Date of deliver Month	very Day Year
sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of death 9 ☐ Unknown				IN OTHER	
Physician/Medical	9 Ll Unknown		in the underlying course of	van in Part I	23e. Did tohac	co use contribute to	the cause of death?
<u>چ</u>	Part II. Other significant conditions contrib	uning to death but flot resulting	in the underlying cause gi	von mit uit ii			bably 4 🛣 Unknown
Completed							
ple	1				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
50					performed 1 □ Yes 2 🕏		2 🗆 No
Be (	25. Was case referred to medical examiner?			26. Place of Death (	Check only one)		
	1 ☐ Yes 250No Hosp	1 Dunpatient 2 EH/	Julpatient 3 DOA			e 6 Other (Spec	ify)
on:	1 Natural 5 ☐ Pending	28a. Dáte of Injury (Month, Day, Year)	D. Time of 28c. Inju Injury Wo	rk?	d. Describe how i	injury occurred	
Certification: To	2 Accident investigation 3 Suicide 6 Could not be	20 Discontinuo Atheres		Yes 2 No	f Location (Street	et and Number or Ru	ral Boute Number
Ę	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	iarm, street, lactory, office	20	City or Town, S		ar rioute Humber,
	29a. Certifier 1 Certifying Physicia	an: To the best of my knowled	Ige, death occurred at the	time, date and place ar	nd due to the caus	se(s) and manner as	stated.
Medical	(Check only one) 2 Medical Examiner:	On the basis of examination	and/or investigation, in my	opinion, death occurred	at the time, date	and place, and due	to the cause(s)
Mec	29b. Signature and title of certifier	Contract States	29c. Licen	se number	29d	. Date signed (Month	, Day, Year)
	( Permene	ear Di	> 040	257		11.7	. 09
	30. Name and address of person who comp	leted cause of death (Item 23a 40) (7324 (2) 32. Registrar's Signature	a) (Type, Print)	2			
		up (0324 or	O CEANCIT	1 (3CAS) A	benero	1, and 2/2	311
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 6-21				
jistrar	NOV 1 0 200	9 Aneur B	. pare				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2608 Chapel Lake Drive #110 Anne Arundel Gambrills 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 M 2 X Months Days Hours (Month, Day, Year) 02-25-1928 Washington, D.C Director 579-32-6770 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Gambrills 1 Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2608 Chapel Lake Drive #110 21054 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ should be Mabel Viola Waxter James Melvin Bradley and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Page 1 and 2 George Talbert - Husband Gambrills, MD 21054 2608 Chapel Lake Drive #110. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1xxBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Catholic Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2009 /2009 Bowie, Maryland Robert E. Evans Funeral Nome Cemetery Church Signature of Funeral Service Licensee 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 MR No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☑ Residence 6 ☐ Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifier Yertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) d title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

gistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 8, 200<sup>y</sup>g<sup>ar</sup> Charlene Frances Tolle 10:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel | Funder 1 Year | Hunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | July | 11, 1945 | Massachusetts 9344 Northgate Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 64 Director 029-34-8158 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐ Yes 2 ☐XNo MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 9344 Northgate Road 20723 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any Injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕍 No If Yes, Give Year or Dates: Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mentor Human Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Thomas Leonard Alice Irene Wereska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Tolle/husband 9344 Northgate Road Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 11/10/09 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licen Coing Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the effsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer year /Medical Due to (or as e consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I was and autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2 📆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical

the death certificate be executed Box 68760. o ۵. The law requires that of Vital Records, spital or Attending Physician: Thours after death.
Ineral Director; After this certifically filled in by the funeral director, py Division Hospital c To the Hospital within 24 hours a To the Funeral D

> 12 State Registrar

29b. Signato

nd title of dertifi

Nicholas W. Koutrelakos, M.D. 10710 Charter Drive #G020 Columbia, MD 21044 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D38509

29d. Date signed (Month, Day, Year)

November 9, 2009

09-08913	
Mary Thompson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certi	ficate of	Death		R	eg. No. 2	00	9 3798
Maal	Physici		Month Day Year 45071									
viea	ical Exami	ner	Mary Jo Thomp  4a. Facility Name (if not institution		-1	-1.	4b. City, Town, or L	ecetion of		r 16, 2009 4c. County of		1527 hrs
			177 E. Nicodemius Ro		' /		Westminster		Death	Carroll	n Death	
	Funeral		Social Security Number	6. Sex 7. A	ge (In yrs. last	birthday)	If Under 1 Year			th(MM/DD/YYYY		nplace (State or
	Director		506-70-0964	-0964 1 M 2xF 56 Yrs. Months Days Hours Min. May 20						1953	Foreign Cou	intry) <b>NE</b>
	÷		Usual Residence of Decedent 10a. State 10b. County		100 City To	own or Locati	ion	-	<u> </u>			10d. Inside City Limits
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ή.	Aaryland 28a-f show 1 at once.	ctor	MD Car	roll	VVE	SUILLI	10f. Zip Code			0g. Citizen of Wh	nat Coun	
)	5-UU36 ed within 72 hours after death with the Maryland tygene other than "natural", or items 23a or 28a-f sho the Medic-I Examiner must be notified at once	Director	177 E. Nicode	mus Road			211	57		USA		
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	U36 zithin sene ene er than	ш		5+		Speec	h & Lang	uage	Pathologis	st Spea	ech :	Pathology
			17. Father's Name (First, Middle,				1		Name (First, Middle,		)	
9	Z1Z15-UU36 unid be filed within 7 Mental Hygiene marked other than c event, the Medic	To Be	Tommy Thompson  19a. Informant's Name/Relationsh			19h Mailine	Address (Street		lene Preus er or Rural Route Nur		m State	Zin Code)
į	J es ga si f	٦	Randy Hulse/hu		1				oad Westn			21157
	re, M 1 and 2 Health Fitem 2 er traum		20a. Method of Disposition			ce of Dispos matory or oth	ition (Name of cem	netery,	Date	20c. Location -	- City or ?	Town, State
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3	baltimo permit. Page Department Important: injury or otl		21. Si u au e of Funeral Sirvi			4°F	inters Africa	efacility	Home and C	hapel,	P.A.	
		111	23a. Part I Enter the disease, or	complication that cause	d the death. D	41	2 Washing	gton	Road West	minster	MD art	21157 Approximate Interval
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	( <b>bU</b> , cate be executed physician and the burial - transit		X UNPENDED	d								-
9	fou, Teate be physicia the buria	/Medical	IF FEMALE:	23c. If yes, outco	PII,2	7,perl	ME, g898	12/2	/09 TT	23d. Date of	delivery	
			23b. Was decedent pregnant in the past 12 months?	e 1 Live birth		<sub>2</sub> Fe	tal death 3	Ectopic	oregnancy	Month	,	Day Year
	GOX 68 (seath certification) the attending and for use as t	Physician	1 Yes 2 No 9 🗸 Unk		at time of death	5 Ot	her (Specify)			10		
	res that the de signed by the be detached f		Part II. Other significant conditi		th but not resu	Iting in the u	ınderlying cause gi	ven in Part	I. 23e. Did t	obacco use contr	ibute to t	the cause of death?
(	ires that the signed by	d by	<u> Hypertensive</u>	e heart dise	ease				1 Ye	s 2 No 3	Prob	ably 4 🗸 Unknown
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:	r Attencter death irector:	ertification		tigation 28e. Place of I	njury - At hom	e, farm, stree	et, factory, office bu	uilding, etc.	28f. Location (	Street and Numb	er or Rui	ral Route Number, City
Ċ	DIVISION OF VITAL RECORDS, P.O. BOX 68 II Suppital or Attending Physician: The law requires that the death certificate has been signed by the attending rely filled in by the funeral director, page 2 should be detached for use as	Certi		mined (Specify)					or Town,	State)		
	DIVISION DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (		nysician: To the best of r	amination and/							
_		Me	29b Signature and title of certifier	and manner stated		0.0	29c. License	number		29d. Date sign	ed (Mor	nth, Day, Year)
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	'		30. Name and address of person			,	111 Dawn Ct	oot Dell	timoro MD 0400	.4		
	St	ate	Patricia Aronica-Pollak 31. Date filed (Month, Day, Year)		Medical Ex ar's Signature	anner	Str	eei, Ball	timore, MD 2120			
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			1- State of Maryland / Dep 23aPt1,11,25,27,28 Registrar	partment of Health and a-f per me, 899,0 prificate of Death	Menta Hyo 1/25/2010 Re		
	Physici		Veronica Mary Valentine		Month	Day Year 10 2009	3. Time of Death 7:55 A M
Mary and	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	7.55 A
العساء			Union Hospital	Elkton		Cecil	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2X F 7. Age (In yrs. last birthday 200-30-0554 88 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.	(Month, Day,	Year) 9. Birthp	* *
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	with the		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
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altimore,	jes 1 al t of Hea <b>If item</b> or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposerery, cree	osition (Name of ematory or other place)	Date 2	20c. Location - City or To	wn, State
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Bal	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		Tan C. IVI h	R.T. Foard Funera 111 S. Queen St.,	Rising S	Sun, MD 219	911
	Physician /Medical Examiner		Sequentially list conditions	Tract Infection  Deep Vein Thrombo	sis		Approximate Interval Between Onset and Death
r.	icate be executed physician and s the burial-transit	Examiner	If any, leading to immediate cause. Enter Underlying	ip Fracture with	sty 296	Hipfx	
8760,	e be e	dical E	HTA		ON A PROVED BY	JEDICAL EXAMINER	
		0	d	CERTIFICA	ON PASSONED BIT	ine.	
P.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive	ry Day Year
ds, Р	iires that signed t	Ώ.	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did toba	acco use contribute to th s 2∑ No 3 ☐ Prob	e cause of death?
S	w requir been s should	etec	Hyperlimidencia Dementia		-		
Vital Records,	ysician: The law is certificate has director, page 2 a	Completed	Arthritis		24a. Was an autopsy perform 1 □ Yes 2	prior to cor death? X No 1 □ Yes	osy findings available npletion of cause of
5	/sicia s cert lirecto	o Be	25. Was case referred to medical examiner?  1 ☑ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie	Other:	ath (Check only one		
Division of	ding Ph	tion: To	27. Manner of Death    1   1   2   2   2   2   2   2   2   2	of p 28c. Injury at Work?	28d. Describe how Subject	nce 6 Other (Specify w injury occurred <b>tripped and</b>	,
Divis	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify) Home		28f. Location (Str. City or Town, Schuykil	eet and Number or Rural State) 65 Waln	Route Number, aut Street
	ne Hospit n 24 hour ne Funera	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the ca	use(s) and manner as st	tated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, L	Day, Year)
			SHAHNAWAZ KHAN MD	D006219	70	11/10/2	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, SHAHNAWAZ KHAN MD III W. H)	Print)		LKTON MI	>21921.
	Stat Registra	e	SHAHNAWAZ KHAN MD III W. HI  31. Date filed (Month, Day, Year) 2 2009  32. Registrar's Signature	bares			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar 1. Decedent's Name (First, Mic		-	Certificate of		, ,	eg. No. 2009	37986
	Physici		Gertrude Alie					Month Novembe	er 8, 2009	3. Time of Death 8:32 A M
Mary .	/Medi Examir		4a. Facility Name (If not institut	tion, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
me de la			732 Largo Dri			Hagerst			Washington	
	Funeral Director		5. Social Security Number  124-24-0788  Usual Residence of Decedent	6. Sex 7. Age	e (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 20,	1932 New	place (State or Foreign intry) York
	yland Jow		10a. State 10b. Coun	nty	10c. City, Town	or Location				10d. Inside City Limits
	Ba-f sl	ctor	MD Wash:	ington	Hagerst	own				12 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	s 23a		732 Largo Dri			21740			SA	
936	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medicel Examirer must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 💆 Married 3 ☐ Widowed 4 ☐ Divorce	If Yes Give		13. Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2 No	an, Mexican, Puerto  Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
Ö N	72 hou	Completed	15. Deced	ent's Education	16a.	Decedent's Usual Occup	pation	. [	16b. Kind of Business/Ir	
2	ithin 7 ne. <b>nan "r</b>	mple	Elementary/Secondary (0-12)	hest grade completed) College (1-4or 5	i+)	(Give kind of work done life. DO NOT use retired				
2	lled w Hygiel her th	ပိ	11 17. Father's Name (First, Middl	(2.4.2.4)	Ch	ildcare Wor			Childcare	
Maryland 21215-0036	e d stal	Be C	Claude Dudley	, ,			Marcia Y	e (First, Middle, N Ouna	iaiden Surname)	
ar Z	should be and Mental s marked o	္	19a. Informant's Name/Relation		19b.	Mailing Address (Street			City or Town. State. Zi	in Code)
ž	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		John W. Vere,	Sr./husband	1	2 Largo Dri				,,
Baltimore,			20a. Method of Disposition	n 3 ☐ Removal from State	20b. Place of cemeters	Disposition (Name of v, crematory or other place	ce)	Date 2	20c. Location - City or T	own, State
Ĕ	: Pages tment of tant: If its jury or o		4 □ Donation 5 □ Other	(Specify)	Final	Journey Cre	matory 11	/10/09 W	oodbine, M	)
Bal	permit. Page Department ( Important: If any injury or once,		21. Signature of Funeral Service	e Geris	MO1251	Going Home Beverly L.	SSCHERCHING TIC Heckrott	on Servic	e P.O. Box CLarksville	x 784 e, MD 21029
			23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that caused ist only one cause on each lin	the death. Do n					Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition resulting in death)	_aME	tastas	ic Lune	Canc	en	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence o	n: of	8-31			
		jer	Sequentially list conditions,	b	n consecuence d	n:				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>C</b>						
Ď,	be exectan a		resulting in death) Last	Due to (or as a	a consequence o	f):				
09/89	rtificate be executed ng physician and as the burial-transit	Medical		d		<u> </u>				
ROX	£ 5, a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of <u>pregnancy</u>	_		(17.7)	23d. Date of deliv	verv
j j	the death ce y the attendi ched for use	Physician/I	in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y 		Month	Day Year
ν. Τ	s that gned b e deta	by Pi	Part II. Other significant condi	tions contributing to death bu	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to t	the cause of death?
ecords,	en sig	edt	-mphe:	sema				1 □ Ye	s 2 □ No 3 □ Pro	bably 4 ☐ Unknown
ဗ္ဗ	law re nas be s 2 sho	Completed	Brain r	netastasis				24a. Was an		opsy findings available ompletion of cause of
VII A	r: The icate l							perform 1 ☐ Yes 2	ed? death? ZNo 1 ☐ Yes	-
<u> </u>	sician certif	Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 No	Hospital:		Oth	or:	h (Check only one		
5	g Phy er this eral d	유	27. Manner of Death	1 ∐ Inpatiel 28a. Date of Injur (Month, Day		me of 28c. Injur	y at Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 Other (Speci	ify)
vision	arth. rr: Aft	atio	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ting (Month, Day stigation	<i>t, Year)</i> In	jury Worl	k? Yes 2 □ No			
	I or Atte after de Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could deter	d not be rmined 28e. Place of Inju building, etc	ry - At home, farr c. (Specify)	m, street, factory, office		28f. Location (Str City or Town	eet and Number or Rur State)	al Route Number,
:	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical C	29a. Certifier (Check only one) Certify	ring Physician: To the best of all Examiner: On the basis of and manner sta	examination and	death occurred at the til l/or investigation, in my o	me, date and place ppinion, death occur	, and due to the ca red at the time, da	ause(s) and manner as ate and place, and due t	stated. to the cause(s)
	To the within To the somply	Me	29b. Signature and title of certific			29c, Licens	e number	29	d. Date signed (Month,	Day, Year)
<b>b</b>			106	L YOUST	ang, na	D D 68	1995		11/9/09	
	5		30. Name and address of perso			Type, Print)				
			Yong Tang, 11 31. Date filed (Month, Day, Yea	130 opal c		agerstown	, MD	21740		
	Stat Registra		NOV 1	2 2009 32. Registra	r's Signature	bowl.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Year conley V. Wheeler November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Begrices Medical Lenter Bultimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funera! Vi<u>rginia</u> 1**X** M 2 □ F Months Days Hours Min. 217-01-7922 92 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c City Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Experience must be notified at 10d. Inside City Limits Director 1 √Yes 2 No Marvland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Martin Road 21078 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces
1 X Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Š Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen, Maryland Twelve Years Machinist Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foy Henry Wheeler or other traumatic ပ Maggie Marlow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winifred W. Wheeler 806 Martin Road, Havre de Grace, Maryland (wife) permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other ODCE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Friends Cemetery 4 Donation 5 Dother (Specify) 11/18/09 Rising Sun, Maryland 21. Signafure of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pheomoria Sequentially list conditions, il any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Examin and burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, in 24 hours the Funeral Dire within 2 To the

> State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Kowee Ws

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howell M.D. 4940

32. Registrar's Signature

Earstein

29c. License number

10842000

Avenue Baltimare, ms

29d. Date signed (Month, Day, Year)

November 14 2009

			1- Registrar  Amend Item 23 State of Merry 9000, 029187/2016 of Heaville of Death  Certificate of Death  Reg. No. 2009 379	88
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  PERCY WILLIAMS  2. Date of Death Month Day Year NOV 14 7009 5.3	Death PM
ray.	Examir	ner	4a. Facility Name (If not institution, give street and number)  HAVFORD METCHAR HOSPITAL  4b. City, Town, or Location of Death  HAVNY DEGRACE  HARFORD	
	Funeral Director		5. Social Security Number 216–16–2618  6. Sex 7. Age (In yrs. last birthday) 95 95 95 97 95 95 96 12 Index 1 Year   If Under 24 Hrs.   8. Date of Birth (Months, Days)   14 PRIL   10   10   10   10   10   10   10   1	or Foreign
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City  MARYLAND HARFORD HAVRE DE GRACE 1 V Yes	
	with the	Il Director	10e. Street and Number  799 S. STOKES STREET  10f. Zip Code 10g. Citizen of What Country? UNITED STATES	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinat must be northed at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married  15 Never Married 2 Married  16 Never Married 4 Divorced  17 Never Married 4 Divorced  18 Never Married 4 Divorced  19 No Specify: Specify: Specify: Specify: Specify: Specify: Specify: AFRICAN	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinat must be notified at once.	Completed by	AMERICAN  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+  AMERICAN  AMERICAN  (Give kind of work done during most of working life. DO NOT use retired)  ASSISTANT SUPERINTENDENT  PUBLIC SCHOOLS	Ŋ
Maryland 2	uld be filed Mental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last)  VANDELLIA A. WILLIAMS  18. Mother's Name (First, Middle, Maiden Surname)  HATTIE E. BROWN	
	ind 2 shou alth and M 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  6324 WINDERMERE CIRCLE, ROCKVILLE, MARYLAND 208	 352
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  UNION UNITED CEMETERY  11/21/09  ABERDEEN, MARYLA	
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  LISA SCOTT FUNERAL HOME, P.A.  552 LEWIS STREET, HAVRE DE GRACE, MD 21078	
ales .	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Bet Onset and I disease or condition resulting in death)  a.	e ween
	ficate be executed XX physician and XX sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):	
O. Box 6	I he law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery	Year
rds, P.	quires that on signed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1	
Division of Vital Records,	stcian: The law requir certificate has been s' irector, page 2 should I	Completed by	ACTURES, DIABETEN IL YAERTENSION,  CARALOMYOLATITY, PRETEUS BACTEROTICA  24a. Was an autopsy performed?  1 yes 2 Ino  1 yes 2 Ino	available ause of
VITA	ding Physician:  7.  After this certific: funeral director, p	To Be C	25. Was case referred to medical examiner?  Yes 2 No  1 Yes 2 No	
ouo	nding Pn ath. r: After th e funeral	ation: T	27. Manner of Death  1 Manual 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	
DIVIS	or en sospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)	ber,
	ne nospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	)
	vith vith con	Σ	29b. Signature apolitile of Certifier 29d. Date signed (Month, Day, Year)  1 2 1 7 3 8 No. 1 (4 200)	7
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ALMN SWEAT MAJ, HANFONS METRORIAL HOPPITAL, HANNE SUE CLA	CE
	Stat Registra		ALAN SUE AT MAJ HANFONS METTORIAL HOPPITAL, HANNES GLA 31. Date filed (Month, Day, Year)  32. Registrar's Signature	,

DHMH 17 Rev 1/2001

ORIGINAL

			State o			. Ensure All C Tealth and Men	•	
		ļ	1 - State Registrar	•	Certificate of			No. 2009 37989
60	Physici /Medic		Decedent's Name (First, Middle, Last)     WILLIAM G. WALKER					Day Year 3. Time of Death 0.7 3009 0338 M
	Examir		4a. Facility Name (If not institution, give street and nu		4b. City, Town, o	or Location of Death		4c. County of Death Wicomico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Dave	If Under/24 Hrs. 8. [	Date of Birth Month, Day, Ye 2-24-19	-
	Director		Usual Residence of Decedent		rs. Mondis Bays	1	2-24-19	ar) 20 IRELAND
	aryland show	Ĺ	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	the Ma 28a-f s	Director	DELAWARE SUSSEX  10e. Street and Number	MILI	SBORO 10f. Zip Code		100	1 Yes 2 No Citizen of What Country?
	3a or	al Dir	312 MORRIS STREET		1996	66	109.	US
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marcal Expression in the Instituted at	by Funeral	Armed Fo	dent Ever in U.S. rces? 2	13. Was Decedent of H If Yes, specify Cub 1 □Yes 2√√ No	Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or is aumatic event, It.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire NAGER	during most of working	Î	. Kind of Business/Industry
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) GEORGE WALKER			18. Mother's Name (Fir FRANCIS		
Mar	d 2 sho th and 7 is ma traum		19a. Informant's Name/Relationship (Type. Print)  NANCY L. CARTER/ DAUGHT:			and Number or Rural Ro		ty or Town, State, Zip Code)
as a	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once.	- 3	20a. Method of Disposition	20b. Place of	Disposition (Name of c, crematory or other place			Location - City or Town, State
Baltimore,	nit. Pages partment o ortant: If i Injury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Sther (Specify)	state ;	S CREMATORY	i	009 FR	ANKFORD, DELAWARE
Ball	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funera Service Consee		43 THATCHER		ANKFORD	, DELAWARE. 19945
	Physician /Medical Examiner				11 Caroro	ng, such as cardiac or res	A	Dinset and Death
.760,	ite be executed ysician and le burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	or as a consequence of				
P.O. Box 68	the death certifica by the attending phached for use as th	Physician/Medi	in the past 12 months?	come of pregnancy irth 2 Fetal death lant at time of death lown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	sy		23d. Date of delivery Month Day Year
rds, F	w requires that been signed I should be deta	þ	Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying cause giv	ven in Part I.		co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ∰ tñknown
of Vital Records,	sician; The law re certificate has be rector, page 2 sho	e Completed	25. Was case referred to medical				24a. Was an autopsy performed	
of Vi	Physicia this cer al direct	To Be	examiner?	npatient 2 ER/Out	oatient 3 DOA Oth			e 6  ☐Other (Specify)
/ision	ding P	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury h, Day, Year)  28b. Ti Inj of Injury - At home, farr log, etc. (Specify)	ury Wor M 1 🗆	Yes 2 □No 28f. L	Describe how in ocation (Street City or Town, St	and Number or Rural Route Number,
	Hospita 4 hours Funeral tely fillec	ledical Cer	29a. Certifier (Check only one) 2□ Medical Examiner: On the beand many and	isis of examination and	death occurred at the ti	me, date and place, and	due to the caus	·
	To the within 2 To the comple	Med	29b. Signature and title of certifier  Maulu Uballu		29c. Licens	se number 37014		Date signed (Month, Day, Year)
E	Sta Registr	te ar	30. Name and address of person who completed cause Manager Man	gistrar's Signature	bakes	a 54 504	13 591	13 1310 m MD 21864
	and grown	004	/A	75.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g899 1-20-10 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 Mildred Frances Witham November 2009 2:00 p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ F Months Hours 577-07-3843 93 Jan. 21, 1916 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 Brisbane Street 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates; 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Archie Hutchison Ethel Pearle Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Barbara J. Carter/Daughter 1331 Alderton Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Respiratory Failure Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Metastatic Lung Cancer Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖺 No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown

**Physician** /Medical **Examiner** Examine The law requires that the death certificate be executed and

**Physician** 

/Medical

10a. State

**Examiner** 

**Funeral** 

Director

show

s 23a or 28a-f shows

Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23.
ury or other traumatic event, the "hacical Even in the County or other traumatic event, the "hacical Even in the County or other traumatic event, the "hacical Even in the County or other traumatic event, the "hacical Even in the County or other traumatic event, the "hacical Even in the County or other traumatic event, the "hacical Even in the County or other traumatic event in the County of

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

Baltimore, Maryland 21215-0036

Director

Funeral

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the Maryland

burial-tran attending physician for use as the buria Physician/Medical as the signed by the ģ completely filled in by the funeral after death

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

24 hours a

within 2 To the

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ted				1 ☐ Yes 2 [	☐ No 3 ☐ Probably 4 🔼 Unknowr					
Medical Certification: To Be Completed				24a. Was an autopsy performed? 1 □Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No					
	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
	1 ☐ Yes 2★ No	Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other:	4 ☐ Nursing Home	e 5 ☐ Residence 6	Cother (Specify)					
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		at 28	d. Describe how injury						
Certific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)							
8	29a. Certifler  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
5	20h Signature and title of contifier	00.11								

31. Date filed (Mont)

29b. Signature and title of certifier ha anica

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

D66372 November 6, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanian Shahri, MD

1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Registrar AMEND#9perINF, 11-17-09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day **Physician** Gail. Francina Werner November 8, 10:15 A 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3007 Paladin Terrace Olney Montgomery 8. Date of Birth (Month, Day, Yea 3/15/1948 9. Birthplace (State or Foreign Country) Virginia
Pennsylvania Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. **Funeral** 1 □ M 2 F Months Days Hours Min Director 164-40-3243 61 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location Show ? is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Invitoral Experient matter multified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3001 Paladin Terrace 20832 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decesion Armed Forces? 1 □Yes 2 No 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify ģ Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Provider Child Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Brahin Lillian Gendelman Sidney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any Injury or other traun Nathan Shapiro, 3007 Paladin Terrace, Olney, Maryland son 20832 Baltimore. 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 ★ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 □ Donation 5 □ Other (Specify) King David Cemetery 11/9/2009 Bensalem, Pennsylvania 21. Signature of Funeral Service Licens, e M00709 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring. MD 20904 darres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TASTA YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) detached 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 ☐Yes 2/XNo 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation † ☐Yes 2 ☐ No after death 6 Could not be 3 ☐ Suicide by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7

State Registrar 18109 Prince Philip Drive, #200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Alneuro

Philip Henjum, M.D.,

30035045

November 8. 2009

Olney. Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charles Franklin Wendel Physician/ Month 2009 November 4:26 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Annapolis 4c. County of Death Arundel 1044 Spa Road, Apt. I Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) an. 4. 1942 107-32-1480 1**XX**M 2 □ F Months Hours Director 67 New York Usual Residence of Decedent sho 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1044 Spa Road, Apt. I 21403 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after ☐ Yes 2XXNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 🗌 Widowed 4 🔲 Divorced Specify traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Counselor Counseling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Wendel Theresa Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sarah Wendel/wife 1044 Spa Road, Apt. I Annapolis, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗀 Burial 2 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory | 11/8/2009 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 000 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death tr teriosc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a consequence of) to immediate I or Attending Physician: The law requires that the death certificate be executed direct death.

Director: After this certificate has been signed by the attending physician and in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 🗌 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital or within 24 hours aft To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month. Day. Year Name and address of person who completed cause of death (Item 23a) (Type, Print) ones

State Registrar 09-08768 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Michael Wike State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death John Michael Wike Medical Examiner November 11, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Carroll Hospital Center Westminster 5. Social Security Number 6. Sex **Funeral** Age (In vrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 195-56-0408 33 1 X M 2 F Jun 25, 1976 Usual Residence of Decedent 10a, State 10c. City, Town or Location Maryland Carroll Westminster after death with the Maryland Director 10e. Street and Number 10f. Zip Code 288 East Main Street 21157 23a Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1 Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married Yes f Yes, Give Yee Yes 2 No specify: Divorced 2 Pages I and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natura or other traumatic event, the <u>Medical Exam</u>in 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 unknown unknown 17. Father's Name (First, Middle, Last) John Christy Wike 19a. Informant's Name/Relationship (Type, Print) Martha Kirkendall, step sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date Sovertatory or other place) Burial 2 Cremation 3 Department of Important: Hi Carroll Crematory Donation 5 Other Specify: 2 Signature of Funeral Service License Physician failure. List only one cause on each line. /Medical Zolpidem and oxycodone intoxication Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit The law requires that the death certificate be executed XUNPENDED **AMENDED** 23a,27,28a-f,permE, G898 12/2/09 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

unknown 18. Mother's Name (First, Middle, Maiden Surname) Sussie Marie Stem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 16 Pennsylvania Ave Apt 12, Westminster, MD 20c. Location - City or Town, State 11/18/2009 Winfield, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 23a. Aart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Physician/Medical 23d. Date of delivery Year Month Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No No 1 🗸 Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other<sub>4</sub> Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Pending Yes 2 XNo unk 11/11/09 11:59 am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State 269 E. Main St Apt 2 Westminster, MD Could not be Suicide (Specify) private dwelling Homicide Westminster, 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME November 12, 2009

111 Penn Street, Baltimore, MD 21201

ORIGINAL

DHMH 17 Rev 1/2001 CME 2006

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Records,

Division of Vital

After this certificate has been funeral director, page 2 should

To the Funeral Director: completely filled in by the

completely

State Registrar

Lina Li. MD

31. Date filed (Month, Day, Year)

To the Hospital or Attending Physician: within 24 hours after death.

2009 37993

1231 hrs

10d. Inside City Limits

1 Yes 2 No

Reg. No

4c. County of Death

10g. Citizen of What Country?

oreian

USA

White, etc.

16b. Kind of Business/Industry

Specify: White

14. Race - American Indian, Black,

Country) PA

Carroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2009 **Physician** 5:50 E M VORMISEN Bety Wood /Medical 4gt. Chimm of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner carrol1 Carroll Hospital Center Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 23 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Ohio 86 Director 286-18-3717 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantrier must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ZYes 2 ☐ No Westminster Director Carroll MD 10g. Citizen of What Country? 10e Street and Number USA 21158 Apt #209 1000 Weller Circle Funeral Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zelpha Barnhart Paul Jesse Fox ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John B. Wood, Sr/husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 Cremation 3 Daemoval from State Arlingtin National Cem 11/24/2009 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Printen Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final evensi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4 Pregnant at time of death P.0. 9 I Unknown signed l d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 🗷 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform Physician: The 1 ☐Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one) After this certifi funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ca 29a. Certifier 1 📝 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only Medi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of pers and accompleted cause of death (Item 23a) (Type, Print) 5 pury enni. 295 30 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c & 30 per DVR 8898 12/1/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2√ F Director Dec 30, 1928 No. Carolina 217-54-3820 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show The Wedical Exa cinst must be notified at 1 XYes 2 ☐ No Director **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 2241 W. Lexington Street 21223 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If fleat 27 is marked other than "natural", or items 23 ury or other traumatic event, it. W. dien Even in ser unup. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u></u> Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lyons Bros. Inc. Janitor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hester Davis Dubley Bill Small ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2241 West Lexington Street Baltimore', Maryland 21223 Department of Health Important: If item 27 any Injury or other tr Walter Andrews 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 12/03/09 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery Sur form Puneral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Futaw Place Baltimore, Md 212 23a Part 1. Effect the disease, or complications that caused the death. Do tenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes funeral director 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural Injury 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number RES000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morgan Dooley, MD Mercy Medical Center 301 St. Paul Pl. Baltimore, MD 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parks

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Gertrude Lavinia Allen 0215AM 2009 LOY /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital N/A Hanes Itimore 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 04/20/1927 **Funeral** 1 □ M 2 🖎 F Months Days Hours 216 20 6975 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It w Medical Examinations to nottlike and 1 X Yes 2 □ No N/A Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2814 Maudlin Avenue 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify Specify: Be Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Tavern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry L. Baker Sr. Sarah Lavinia Smelter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Tarleton / Daughter 3242 Ryerson Circle Baltimore, Maryland 21227 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 12/01/2009 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Fert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Closheden Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐Yes 2 ☑ No or Attending Physiciar: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To sion of sompletely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 ☐ Could not be 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

CHARLES R 31. Date filed (Month, Day, Year) PINE HUSTED AME 5300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

GRANM

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Farmyre

November 29

2005

		_	State of Maryland / Department of Health and Mental Hygiene								3799		
	Physician/ Medical		Registrar  1. Decedent's Name (First, Mid	dle, Last)	ast)		Certificate of Death		Reg. No. Z U U		2009	3. Time of Death	
77			LOUIS		JEROME			APPLEFELD		Month November	Day	Year 2009	9:50 PM
	Examin		4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. la	st birthday)		M DIZE  If Under 24 Hrs.	8. Date of Birt	th	N/A 9, Birtho	lace (State or Foreign
	Director		218-36-7891	1 [X] M 2 [	F	67	Yrs.	Months Days	Hours Min.	05-15-	1942	Coun	
	and show at	٥	Usual Residence of Decedent  10a. State 10b. Coun	ty		10c. City	, Town or Loca	ation				1	Od. Inside City Limits
	Maryla 28a-f s atified	rect	MD BALT	IMORE		LU	THERVIL	.LE					1 ☐ Yes 2 💢 No
	s 23a or sust be n	Funeral Director	10e. Street and Number 11604 WOODLAND	DRIVE				10f. Zip Code 21093				zen of What Coun USA	try?
11 d 0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 🛣 M 3 ☐ Widowed 4 ☐ Divorc	Armo 1 1 If Ye	Decedent Eved Forces? Yes 2 1 Nes, Give			as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White, e Spec <i>ify:</i>	
in as splefeld 21215-0036	within 72 ho giene. Ier than "nat	<b>Completed</b>		dent's Education whest grade comp ) Colle	ege (1-4 or 5+ 5+	+)	(Give ki. life. DO	ent's Usual Occupa nd of work done o NOT use retired) ERINARIA	luring most of work	ing	ľ	nd of Business Inc	,
Seat Know ou's Ap	id be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle SYDNEY	, Last)		API	PLEFELI	)	18. Mother's Nam CLARA	e (First, Middle,	Maiden S	Surname)	POLT
Patient Enoun Louis App ore, Maryland 2	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relation		)		·		ND DRIVE,				0de) 1093
الم 1 Baltimore,	Page 1 ament of Hament: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		I from State	ce	emetery, crema	ition (Name of atory or other plac E HEBREW	e) 11-2	Date 29-2009	REI	cation - City or To STERSTOW	N, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Livensee	ger			Name and Addres	ss of Facility SC	L LEVIÑ ROAD, P	ISON PIKES	& BROTHE VILLE, M	RS, INC. D 21208
	Pnysician,	e i	20a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final										
	Medical Examiner		resulting in death)		a. Intracrania nemorinage  Due to (or as a consequence of):							days	
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Box 6876	eath certifica attending ph for use as th	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If ye	s, outcome o	of pregnan	icy	Ectopic pregnanc			2	23d. Date of delive	ry
). Bo	that the death ned by the atte detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 🗆	Pregnant at Unknown			Other (specify)	у			Month	Day Year
ds, P.O.	The law requires tha ate has been signed page 2 should be de	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to to the problem of the problem o										
Division of Vital Records,		Completed	previous heart block  24a. Was an autopsy performed?  1   Yes   2   No   1   Yes						sy findings available npletion of cause of				
ital	sician: The certificate rector, pag	m	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	al Hospital:				Otho	ace of Death (Chec			_	
n of V	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	cate: To	27. Manner of Death  1  Natural 5 Pen		Date of injury (Month, Day,	/ 12	ER/Outpatient 28b. Time of injury	28c. Injury work	at	ome 5 L Resid 28d. Describe h		Other (Specify) occurred	
Divisio		Certificate;	3 Suicide 6 Cou	ld not be 28e.	Place of Injur building, etc.		ne, farm, stree	et, factory, office		28f. Location (S City or Tow		Number or Rural	Route Number,
	he Hospit in 24 hour he Funera pleted fille	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	To the I within 2 To the I comple		29b. Signature and title of certifier  29c. License number  29d. Date signed (Mon. Dec. 1)  29c. License number  29d. Date signed (Mon. Dec. 1)  29d. Date signed (Mon. Dec. 1)										
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15	Stat Registra		31. Date filed (Month, Day, Year,						w. Belv	ECUTE A	, Da	it moz M	1) 21215
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? \(\) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** ROWN 0045 M MER 24 09 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 901 Jay Court Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**Z**M 2□ F Months Days Yrs. Director 162-26-5552 77 05/14/1932  $\dot{\mathrm{MD}}$ Usual Residence of Decedent 10a State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Dr. Medical Even, That the natified at Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Jay Court 21061 72 hours after death Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify. þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other the any injury or other traumatic event, Inc. Once. 8 Quality Control Radar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph F. Brown Ethel M. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3614 Lord Baltimore Way, Mr. Dale R. Brown / son Monkton, MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 11/30/09 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. NO1357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CA Physician METASTATIC LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a eunesquanes of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 ☐ Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 24a, Was an certificate 1 □Yes 2 **N**o director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 🗆 No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner tated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) within 2 To the I 29b. Signature and title of certific pleted cause of death (Item 23a) TOXENSE IT GHWAY

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 :440 M ovembe: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6265 Wild Swan Maryland 21045 Howard County olumbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖵 F Months Hours 146-14-2918 86 Director New Jersev Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Columbia Howard 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6265 Wild Swan Way 21045 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked can jury or other traumatic eve once. မ Marino De Mahia Lena De Luca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bednarcik/Son 7706 St. George Place, Ijamsville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 11/30/2009 Hanover, Maryland Ardent Cremation Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ardent Cremation Services Jama ( M0119 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ∜tiyəiviait/ months Adeno Cas cintima disease or condition . Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No as been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛮 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performed? Yes 2 No certificate 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signatur and title of certifie 29c. License number

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48DL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 38000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Novembo 2220PM 2009 John Alexander Boling Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Deat 4c. County of Death Examiner Sa osedale 7. Age (In yrs. ast birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **⊠**M 2 □ F Months Hours Nov. 11, 1931 215 28 6256 Director 78 Georgia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Middle River Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 204 Wampler Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No δ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Yes 2 No Specify: Specify: White Completed 3 Midowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Transportation Steel Mfg. 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Armstrong Beecher Boling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Plateau Rd. Baltimore, Maryland 21221 John Alexander Boling Jr. (Son) 27 Important: If item 27 any injury or other tronce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Bel Air Mem. Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/2/2009 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) a Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hospital or Attending Physician: The law requires 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 X N certificate has completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t injury 1 X Natural 5 Pending work? 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) attanasio worded 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) adelphia Rd. Cunte 108 31. Date filed (Month, Day, State Registrar